HARVARD MEDICAL ALUMNI BULLETIN

July / August 1975

The Doctor

Since 1812, The New England Journal of Medicine has played its role in medical circles—reporting the progress of medicine to physicians and medical students throughout the world.

The New England Journal of Medicine

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Right. J. Englebert Dunphy '33 and William V. McDermott '42, alumni presidents past and current, respectively, at Alumni Day. Below: Dean Ebert confers the M.D. degree on Class of '75 at Class Day exercises.

Credits: p. 12, courtesy of the Rare Book Room of the Countway Library; pp. 1 (bottom), 15, 18, 20-23, 25, 29, 31, 37-43, 45, 46-47, Christopher Morrow; pp. 1 (top), 16, 19, 26, 32-36, 50, 52, 54, 56, 58, Kenneth Bernstein.

Cover: The 1891 painting The Doctor, *by Sir Luke Fildes, amply summarizes the tone of this combined Alumni and Class Day issue. Dr. Judah Folkman, guest speaker at Class Day, alludes to its significance in the context of medical education in his address that starts on p. 39, and we are in his debt for providing us with the photograph of the painting.*

HOW MUCH PRODUCTIVE IN THE

Approximately 70% of deaths caused by acute myocardial infarction take place before the patient reaches the hospital.[1] Delay in obtaining medical care is cited as a major cause for this high incidence, and denial may contribute to this delay.

This denial in the cardiac patient is a more obvious aspect of anxiety that is *not* productive. There are others; for example, the previously self-reliant patient who, on finding himself suddenly dependent, reacts with hostility, refuses to cooperate and thus causes serious problems during the intensive care and early rehabilitative stages of his hospitalization.

Even more common, perhaps, is the postcoronary patient who fears a return to work and other everyday activities. The basis for this "cardiac neurosis" is the patient's notion that activity itself is life-threatening.[2]

When anxiety is productive

A certain amount of anxiety in the cardiac patient is both realistic and normal. And in some patients it can be productive. In the acute phase of the disease, it can prompt the patient to seek immediate medical attention. Later, it can encourage cooperation during hospitalization.

In the rehabilitative phase, productive anxiety can help a patient adhere to a possibly difficult medical regimen: to eat properly, to exercise in a manner compatible with his capacities, to alter habits such as smoking. Productive anxiety can hasten recovery—even prolong life.

Channeling anxiety into productive areas

Because unresolved anxiety can lead to psychologic defense mechanisms such as denial which may worsen the cardiac condition, open and ample discussion between physician and patient must be maintained and encouraged. In this way, the patient can verbalize his fears and the physician can help alleviate the patient's anxiety through reassurance and counseling.

Librium®(chlordiazepoxide HCl): often an excellent adjunct to your reassurance and counseling

Although the physician may attempt to help the cardiac patient cope with varied emotional problems through reassurance and counseling,

ANXIETY IS CARDIAC PATIENT?

excessive anxiety may persist. In this case, you may wish to consider the use of Librium, adjunctively.

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Although clinical studies have not established a cause and effect relationship, you should also be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and Librium.

References: 1. Zohman BL: *Geriatrics* 28:110-119, Feb 1973. 2. Keegan DL: *Can Fam Physician* 19(3):66-68, Mar 1973.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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BASIC WHEN ANXIETY AGGRAVATES ORGANIC DISEASE

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Overview

Faculty Accepts Admissions Report

The report of the Admissions Review Committee, submitted to the faculty of medicine on April 25, 1975, was overwhelmingly approved by those present at the May 29 faculty meeting.

Responses to the report from two student groups were also registered at the May meeting. Dean Robert H. Ebert reported receipt of a resolution from the student Third World Caucus, calling for the addition to the Admissions Committee of a member selected by the caucus and appointed by the dean. Samuel W. Casscells '78, speaking for a group identifying with financially and culturally deprived white students, said that they were in accord with the review committee report, but expressed the hope that more effort would be made to identify possible applicants from this group and encourage and aid them in applying. A resolution embodying the views of this group, along with the resolution from the Third World Caucus, will be formally introduced at the October faculty meeting.

Election Tidings

The results of the 1975 Alumni Council election are in. Alexander H. Bill '39, president-elect, and John P. Merrill '42, secretary, are the new officers. Elected to the council for three-year terms are: Fourth Pentad (1955-59): Edward C. Atwater '55; First Pentad (1970-74): Patricia Challender Come '72; At Large: John P. Dixon '62. Those distinguished alumni who were willing to be candidates but who were not elected include: John A. Schilling '41, J. Gordon Scannell '40, Claire Martin Stiles '56, Douglas G. Kelling, Jr. '72, and Americo A. Savastano '32.

The ballot count, at 2,508 — with 183 disqualified for lack of signatures — was down somewhat from last year's high of 2,721 with 114 unsigned. However, this year's assertion of alumni power still surpassed that of 1973 and 1972, when 2,205 and 2,215 votes, respectively, were cast.

Thayer Cumings Designated Alumnus

Thayer Cumings, formerly vice chairman of the Program for Harvard Medicine during its fifty-eight million dollar drive, has become the fifth individual in the history of the Medical School to be elected to full-fledged alumni status. In announcing the Alumni Council's decision at the annual meeting on May 30, retiring alumni president J. Englebert Dunphy '33 praised Mr. Cumings as "a devoted friend of the Harvard Medical School who has given many years of faithful and effective service to its affairs."

Mr. Cumings, who is presently a member of the Medical School's committee on resources, is a graduate of Harvard College Class of 1923.

Fawcett Joins Administration

The appointment of Don W. Fawcett '42 as senior associate dean for preclinical affairs in the faculty of medicine, effective February 1, 1975, completes a major administrative reorganization of the dean's office. About two years ago, after a structural study of the administration, Dean Robert H. Ebert made the decision to streamline and decentralize his office by elevating the triad of associate deanships into senior associate deanships and delegating increased responsibilities to these posts. Already serving under this reorganization are Jack R. Ewalt, M.D., senior associate dean for clinical affairs since October 1973; and Henry C. Meadows, senior associate dean for administration since October 1973, and part of the administration since 1958.

At present, Dr. Fawcett will continue his academic appointments as Hersey Professor of Anatomy and James Stillman Professor of Comparative Anatomy. He has been succeeded as chairperson of the department by Elizabeth D. Hay, M.D., the Louise Pfeiffer Professor of Embryology.

Student Affairs Office Headed by Poussaint

Dr. Poussaint

The Office of Student Affairs has a new director — Alvin F. Poussaint, M.D., who has been working with HMSers as associate dean of students and as associate professor of psychiatry since 1969. Serving with him as associate dean of student affairs is Hermann Lisco, M.D., who is also associate professor of anatomy.

A man of wide-ranging interests, Dr. Poussaint has done research in areas including the psychology of the black power movement and of white workers in the civil rights movement.

Before joining the faculty here, Dr. Poussaint was director of psychiatry at the Columbia Point Health Center in Boston and assistant professor of psychiatry at the Tufts University School of Medicine. During 1965-66, he was Southern field director of the Medical Committee for Human Rights in Jackson, Mississippi.

A new book co-authored by Dr. Poussaint, *Black Child Care,* was recently published by Simon and Schuster. An earlier book, *Why Blacks Kill Blacks,* was published by Emerson Hall in 1972.

Boylston Society Honors Folkman

M. Judah Folkman '57 is the recipient of this year's Boylston Medical Society Award for Teaching Excellence in Clinical Medicine. Dr. Folkman, who is the Julia Dyckman Andrus Professor of Pediatric Surgery at HMS and chief of general surgical services at The Children's Hospital Medical Center, was elected to this honor by members of the Medical School Classes of 1975, 1976, and 1977.

Presentation of the award was made at the annual Boylston Society dinner on April 30, by Jon R. Polansky '75 and Robert N. Weinreb '75, respectively past and present student presidents of the society. Accompanying it was this citation: "To Dr. M. Judah Folkman, Andrus Professor of Surgery, who has set an example as a complete clinical instructor — at the bedside, lecture and laboratory settings. We, the students of Harvard Medical School, recognize the value of your contributions to medical education and thank you for your enlightened concern."

Another highlight of the Boylston Society dinner was the presentation of recognition plaques to Herbert Benson '61, associate professor of medicine, the retiring faculty president of the society; and to past president Francis D. Moore '39, the Moseley Professor of Surgery and chief of surgery at the Peter Bent Brigham Hospital. The faculty president for 1975-76 is Franz J. Ingelfinger '36, editor of *The New England Journal of Medicine*.

The evening's speakers were Harvard University President Derek C. Bok and Medical School Dean Robert H. Ebert. In his talk, "The Future of the Private University," President Bok spoke of the dangers of excessive federal controls tied to federal funding of educational as well as research programs. Dean Ebert expressed opposition to the establishment of identical guidelines for all medical institutions, and urged that federal legislators take advantage of the particular abilities of the nation's different medical schools.

Harvard, Brockton VA Form Mutual Accord

Under a memorandum of agreement signed last spring, the Brockton Veterans Administration Hospital and the Harvard Medical and Dental Schools are cooperating to provide training for residents in psychiatry and dentistry. The affiliation also involves the hospital in an integrated psychiatric residency program with the Massachusetts Mental Health Center. According to future plans, the cooperative arrangement will later be expanded to include education and training programs in medicine and surgery.

Amos, Eisenberg Hold Presley Professorships

Harold Amos, Ph.D., and Leon Eisenberg, M.D., have been named, respectively, the Maude and Lillian Presley Professor of Microbiology and Molecular Genetics, and the Maude and Lillian Presley Professor of Psychiatry.

The newly established professorships were made possible by a bequest to Harvard University from Fred Y. Presley of New York City, a pioneer in mutual funds, who died in 1963. The chairs are named in honor of his mother, Mrs. Maude Presley Williams, and his sister, Mrs. Lillian Presley Perkins, both of whom are deceased.

Dr. Harold Amos, who joined the HMS faculty in 1952, has done research concerned primarily with mammalian cell metabolism, particularly the control of protein synthesis and, more recently, with glycoprotein synthesis. Some of his most noted studies provided strong evidence for the universality of the genetic code.

Appointed chairman of the department of bacteriology and immunology (now the department of microbiology and molecular genetics) in 1968, Dr. Amos served in that capacityy until 1971. Since then, he has been professor of microbiology and molecular genetics, associate dean of the faculty of medicine for the basic medical sciences, and chairman of the division of medical sciences at HMS. He also served for fifteen years as a tutor in biochemical sciences in the faculty of arts and sciences, and was a member of the standing committee on the Afro-American studies program.

From 1955 to 1969, Dr. Amos held a Career Development Award from the NIH National Institute of Allergy and Infectious Diseases. He has been a member of the National Cancer Advisory Board of the National Cancer Institute since 1972. He is former chairman of the Josiah Macy, Jr. Foundation committee for minority faculty fellowships, a member of the board of directors of the Macy Foundation, and chairman of the committee on minority participation of the American Society for Biological Chemists.

Dr. Eisenberg

Dr. Amos

Dr. Leon Eisenberg has been involved in activities related to both public health and preventive psychiatry. He has devoted considerable time to studying the public health implications of the inadequate foster care provided by many welfare agencies. In studies concerning the relationship between social class and academic achievement, he demonstrated the great influence of environmental factors on academic ability and achievement. He has done research in areas of child psychiatry including infantile autism, chlildhood schizophrenia, and the use of stimulant drugs in treatment of hyperkinetic behavior disorders.

Dr. Eisenberg came to HMS in 1967 as professor and head of the department of psychiatry at the Massachusetts General Hospital. Currently, he is serving at the Children's Hospital Medical Center, and is also chairman of the executive committee of the HMS department of psychiatry. From 1970 until June 1975, he chaired the admissions committee here.

Before coming to Harvard, Dr. Eisenberg was associated with Johns Hopkins University Medical School and Hospital from 1952 to 1967, serving as professor of child psychiatry from 1961. In 1973 he was awarded an Honorary Doctor of Science degree from the University of Manchester, England. He has been a member of the US National Committee on Vital and Health Statistics, the Scientific Group on Mental Health, the World Health Organization, and the Joint Commission on Mental Health of Children.

Silen Appointed to New Johnson & Johnson Chair

Dean Robert H. Ebert has announced the establishment of the Johnson & Johnson Professorship in Surgery in the faculty of medicine, funded with gifts from Johnson & Johnson Associated Industries Fund and from the Beth Israel Hospital. The chair's first incumbent will be William Silen, M.D., who is surgeon-in-chief and head of the department of surgery at the Beth Israel, and has received five citations for excellence as a teacher.

Dr. Silen, the new Johnson & Johnson Professor, is in his tenth year here as professor of surgery at HMS and surgeon-in-chief at the Beth Israel. Since 1969, he has also directed an NIH-funded postdoctoral training program in academic surgery. In his own research, Dr. Silen has been recognized as a leader in studies on gastrointestinal physiology, having made important contributions to the understanding of the effects of portacaval shunting and of the pathogenesis of stress ulceration of the stomach. In 1973, under a John Simon Guggenheim Fellowship, he spent a sabbatical year in the department of physiology at the University of California studying the stomach's mechanisms of protection against ulceration.

Ladd Surgical Chair Goes to Castenada

Aldo R. Castenada, M.D., internationally recognized expert on infant congenital heart defects, and cardiovascular surgeon-in-chief at the Children's Hospital Medical Center, has been named the William E. Ladd Professor of Surgery at HMS. His appointment was proposed by Judah Folkman '57, Julia Dyckman Andrus Professor of Surgery and surgeon-in-chief at CHMC.

The Ladd Chair, established in 1940 with contributions from patients and friends of Dr. William E. Ladd, then chief of surgery at CHMC, has historically been held by a pediatric surgeon there — first by Dr. Ladd until 1947, and then by Dr. Robert E. Gross until his retirement in 1972. However, when in 1967 a separate department of cardiovascular surgery was created, and simultaneously Dr. Folkman became the new chief of general pediatric surgery, the Andrus Chair was established to support the incumbent of the general surgical post.

Since joining the HMS faculty in 1972, Dr. Castenada has done pioneering work in the early complete correction of complex congenital cardiac malformations under deep hypothermia, with an outstanding overall success rate. In animal research, he has achieved the simultaneous transplantation of heart and lungs in baboons. The primates have survived for more than two years, affording Dr. Castenada the opportunity to study in detail the changes in cardiovascular dynamics as their organs respond to a denervated state. Previously, unsuccessful attempts with other animals had led to the belief that simultaneous transplantation was impossible.

Ryan Becomes Director of West Roxbury VA

Richard M. Ryan, Jr., M.D., lecturer in preventive and social medicine and former special assistant to the dean at HMS, has been appointed director of the West Roxbury Veterans Administration Hospital.

Dr. Ryan is the first director in the nationwide Veterans Administration hospital system to hold a Doctor of Science degree in Health Services Administration. He received that degree in 1972 from the Harvard School of Public Health.

CLASSIFIEDS

DeBary, Florida: Resident general practitioner needed by community of 5,000, predominantly middle income retirees, near Daytona Beach, Orlando, and Deland. Within eleven miles of three fully accredited hospitals with a total of 470 beds. Financial assistance available for initial office and clinic needs. Contact: Alan R. Edwards, President, DeBary Civic Association, Box 115, DeBary, Florida 32713.

Ellery, New York: Town on Chautauqua Lake in western New York seeks general practitioner. Within twelve miles of two hospitals. Office space available. Call (716) 386-3465 or write: Town of Ellery, P.O. Box J, Bemus Point, New York 14712.

Mechanicsburg, Ohio: HMS '71 and '67, both board certified (ABIM and ABS), seek recent graduate interested in pediatrics or family practice to join problem-oriented rural practice. Relaxed atmosphere, excellent new hospital, university thirty miles away. Write: Darby Medical Associates, 15 North Main Street, Mechanicsburg, Ohio 43044.

Internship List

Abercrombie, Barbara A.
Montefiore Hospital Center,
Medicine

Allman, Frank D.
San Francisco General Hospital,
Family Practice

Altbaum, Robert A.
Massachusetts General Hospital,
Medicine

Badaracco, Mary Anne D.
Jewish Hospital of Missouri, St. Louis,
Medicine

Banks, Gilbert W.
Roger Williams General Hospital,
Providence, *Medicine*

Barnett, Bruce P.
Children's Hospital Medical Center,
Pediatrics

Bigby, Michael E.
Massachusetts General Hospital,
*Medicine**

Black, Preston R.
Peter Bent Brigham Hospital,
*Surgery**

Blumenthal, David
Massachusetts General Hospital,
*Medicine**

Boone, Thomas J.
University of California Affil. Hospitals,
Davis, *Family Practice*

Bor, David H.
Presbyterian Hospital, New York,
Medicine

Botstein, Gary R.
Beth Israel Hospital,
Medicine

Bradley, Edward C.
Beth Israel Hospital,
Medicine

Braslow, Nelson M.
Massachusetts General Hospital,
Medicine

Brooks, Barry H.
Highland Hospital, Rochester,
Family Practice

Broome, Claire V.
University of California Hospitals, San
Francisco, *Medicine*

Brown, Eric J.
Beth Israel Hospital,
Medicine

Brown, Robert H.
Peter Bent Brigham Hospital,
Medicine

Bruce, Calvin S.
University Hospitals, Madison, Wisconsin
Family Practice

Burgett, Lettie M.
Los Angeles County Harbor General,
Torrance, *Pediatrics*

Cabrera, Edna E.
Bronx Municipal Hospital Center,
Pediatrics

Calderwood, Stephen B.
Massachusetts General Hospital,
Medicine

Caldwell-Stair, Thomas O.
New England Deaconess Hospital,
*Surgery**

Calkins, David R.
University of Washington Affiliated
Hospitals, Seattle, *Medicine*

Casey, Rosemary De L.
Children's Hospital of Philadelphia,
Pediatrics

Chin, David C. K.
Beth Israel Hospital,
Medicine

Clark, Luther T.
Roosevelt Hospital, New York,
Medicine

Cobo, Lionel M.
Bascom Palmer Eye Institute, Miami,
Ophthalmology

Cohan, Lawrence D.
Massachusetts General Hospital,
Pediatrics

Cohen, Arnold N.
Hospital of the University of Pennsylvania,
Medicine

Cohen, Elizabeth J.
Hospital of the University of Pennsylvania,
Medicine

Cohen, Jonathan J.
University of Texas SW Affiliated Hospitals,
Dallas, *Medicine**

Cohen, Wendy A.
Boston City Hospital,
Surgery

Connair, Michael P.
New England Deaconess Hospital,
*Surgery**

Crowder, Leonard E.
NYU — University Medical Center,
*Surgery**

Dana, Bruce W.
University of Oregon Medical Center,
Portland, *Medicine*

Eliopoulos, George M.
Presbyterian Hospital, New York,
Medicine

Enriques, Nelson R.
Bascom Palmer Eye Institute, Miami,
Ophthalmology

Fahey, Stephen R.
Massachusetts General Hospital,
Pediatrics

Fanta, Christopher G.
Peter Bent Brigham Hospital,
Medicine

Farrell, Elaine E.
Stanford University,
Pediatrics

Farrer, William E.
Montefiore Hospital Center,
Medicine

Feinsod, Fred M.
University Hospitals, Madison, Wisconsin,
*Medicine**

Fisher, Linda A.
Jewish Hospital of Missouri, St. Louis,
Medicine

Fleischnick, Ellen A.
Children's Hospital Medical Center,
Pediatrics

Frame, Lawrence H.
NYU — University Hospital,
Medicine

Gardner, Renee V.
Children's Hospital of Buffalo,
Pediatrics

Garrison, Richard C.
Mayo Graduate School of Medicine,
Pathology

Gerbarg, Patricia L.
The Cambridge Hospital,
Flexible

Gerhart, Tobin N.
New England Deaconess Hospital,
*Surgery**

Giron, Jose A.
Mt. Sinai Hospital,
Medicine

Goldberg, Ira J.
NYU — Bellevue Hospital,
Medicine

Golino, Andre J.
Monmouth Medical Center, Long Branch, New Jersey, *Surgery*

Guyton, Steven W.
Massachusetts General Hospital, *Surgery*

Halperin, John J.
University of Chicago Clinics, *Medicine*

Hammond, Ray A.
New England Deaconess Hospital, *Surgery**

Hansen, Reid H.
Massachusetts General Hospital, *Surgery*

Harper, Morris E.
Roosevelt Hospital, New York, *Medicine*

Harrington, Martin E.
Roosevelt Hospital, New York *Medicine*

Harter, Carol
University Hospital, San Diego, *Obstetrics-Gynecology**

Hauser, Stephen L.
The New York Hospital *Medicine*

Hochman, Ronald N.
Boston City Hospital, *Medicine*

Hodapp, Elizabeth A.
The Cambridge Hospital, *Flexible*

Holbrook, John A.
Springfield Hospital, *Medicine*

Iglehart, James D.
Duke University Medical Center, *Surgery*

Jacobs, Judith M.
University of California Hospitals, San Francisco, *Surgery*

Jaffee, Kenneth M.
Children's Center, University Hospital, Seattle, *Pediatrics*

Jason, Janine M.
Children's Hospital, Los Angeles, *Pediatrics*

Johnson, Houston
Massachusetts General Hospital, *Surgery*

Kaplan, Julius A.
University of California Affil. Hospitals, Davis, *Family Practice*

Kay, Howard H.
Yale-New Haven Medical Center, *Pediatrics*

Kelleher, Stephen P.
University of Texas SW Affiliated Hospitals, Dallas, *Medicine**

Kerr, Derek L.
Harlem Hospital, *Medicine*

Kita, Michael W.
Lancaster General Hospital, Lancaster, Pennsylvania, *Family Practice*

Klein, Kenneth B.
University of Oregon Medical Center, Portland, *Medicine*

Krauthammer, Charles I.
Massachusetts General Hospital, *Psychiatry*

Kreiss, Kathleen
University of California Hospitals, San Francisco, *Medicine*

Kurtz, David W.
Albert Einstein Medical Center, *Medicine*

Kwasnik, Edward M.
Peter Bent Brigham Hospital, *Surgery**

Ladenson, Paul W.
Massachusetts General Hospital, *Medicine*

Lerner, Corey E.
Long Island Jewish Hospital, New York *Medicine*

Lerner, Henry M.
Grady Memorial Hospital, Atlanta, Georgia, *Surgery**

Letvin, Norman L.
Hospital of the University of Pennsylvania, *Medicine*

Li, Lynn
Peter Bent Brigham Hospital, *Medicine*

Lieberman, Paul B.
NYU — Bellevue Hospital, *Medicine*

Luk, Gordon D.
Johns Hopkins Hospital, *Medicine**

Lukawski, Edward M.
Veterans Administration Hospital, Cleveland, *Medicine*

MacKay, Alexander R.
University of California Hospitals, San Francisco, *Neuro. Surgery**

Macknin, Michael L.
Massachusetts General Hospital, *Pediatrics*

Magoon, Martha C. W.
Children's Hospital Medical Center, *Pediatrics*

Maloney, Joseph G.
University of Colorado, Denver, *Flexible*

Martin, Ramon F.
Yale-New Haven Medical Center, *Surgery*

Matos, Jeffrey
Beth Israel Hospital, *Medicine*

McEvoy, Victoria R.
Boston City Hospital, *Pediatrics*

Meyer, Timothy W.
Stanford University, *Medicine*

Modest, Geoffrey A.
Cook County Hospital, Chicago, *Family Practice*

Moore, John B.
University of Colorado Affiliated Hospitals, Denver, *Surgery*

Moore, Melinda
Mount Auburn Hospital, *Medicine*

Morgan, Richard J.
Massachusetts General Hospital, *Surgery*

Mulley, Albert G.
Massachusetts General Hospital, *Medicine**

Neal, George D.
Vancouver General Hospital, *Surgery*

Nussbaum, Robert L.
Barnes Hospital, St. Louis, *Medicine*

Palma, C. Roberto
University of California Hospitals, San Francisco, *Surgery*

Pasternack, Mark S.
Massachusetts General Hospital, *Medicine*

Persson, Mindy E.
Massachusetts General Hospital, *Pathology*

Peterson, Donald D.
Hospital of the University of Pennsylvania, *Medicine*

Petitti, Diana B.
University of Colorado Affiliated Hospitals, Denver, *Medicine*

Podolsky, Morris
The Cambridge Hospital, *Flexible*

Polansky, Jon R.
University of California Hospitals, San Francisco, *Medicine**

Puck, Jennifer M.
St. Louis Children's Hospital, *Pediatrics*

Pyeritz, Reed E.
Peter Bent Brigham Hospital, *Medicine*

Quevedo, Sylvestre G.
University of Arizona Affiliated Ed. Program Tucson, *Family Practice*

Quinn, Kathleen
Boston City Hospital, *Pediatrics*

Ramsey, Paul G.
The Cambridge Hospital, *Medicine*

Reider, Bruce
Presbyterian Hospital, New York, *Surgery*

Reinherz, Ellis L.
Massachusetts General Hospital, *Medicine*

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Boston City Hospital, *Pediatrics*

Rigau, Jose G.
Children's Hospital Medical Center, *Pediatrics*

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Mount Sinai Hospital, New York, *Medicine*

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Presbyterian Hospital, New York, *Surgery*

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Hartford Hospital, *Surgery*

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Shamberger, Robert C.
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Sherrod, Jessie L.
University of California Hospitals, Los Angeles, *Pediatrics*

Shields, Mark C.
Michael Reese Hospital, Chicago, *Medicine*

Shulman, Lawrence N.
Beth Israel Hospital, *Medicine*

Steller, Richard N.
Bronx Municipal Hospital Center, *Medicine*

Stephens, Harvard W.
Harlem Hospital, *Medicine*

Stone, Jeffrey D.
Massachusetts General Hospital, *Oral Surgery, Surgery*

Strasburger, Victor C.
Children's Center, University Hospital, Seattle, *Pediatrics*

Swerdlow, Steven H.
Beth Israel Hospital, *Pathology*

Tan, Heng S.
Mount Auburn Hospital, *Medicine*

Tenen, Daniel G.
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Tennison, Michael B.
Los Angeles County Harbor General, *Pediatrics*

Troy, James L.
Presbyterian Hospital, New York, *Medicine*

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Vernon, Andrew A.
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Visner, Marc S.
University of Minnesota Hospitals, Minneapolis, *Surgery*

Vlahakes, Gus J.
Massachusetts General Hospital, *Surgery*

Walker, Alexander M.
Massachusetts General Hospital, *Pediatrics*

Weil, Gary J.
Yale-New Haven Medical Center, *Medicine*

Weinreb, Robert N.
Cedars-Sinai Medical Center, Los Angeles, *Medicine*

Weinstein, Alan M.
Beth Israel Hospital, *Medicine*

Weinstein, Mark J.
Case Western Reserve Affiliated Hospitals, *Medicine*

Weisul, Jonathan P.
University of California Hospitals, San Francisco, *Surgery*

Widman, David
NYU-Bellevue Hospital, *Medicine*

Wolejko, Raymond E.
Darmouth Affiliated Hospitals, *Medicine*

Wood, Alan B.
University of Michigan Affiliated Hospitals, *Medicine*

Yonkondy, Joanne K.
Children's Hospital of Philadelphia, *Pediatrics*

Zaleske, David J.
Massachusetts General Hospital, *Surgery*

Zaslov, Ricki
Mount Auburn Hospital, *Medicine**

Zeisul, Steven H.
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"A Meeting of Gentlemen"

by Dorothy A. Murphy

At the winter meeting of the Alumni Council, Harvard Medical School's resident historian, Dorothy Murphy, gave an informal account of the antecedents of the alumni association and the first stirrings of alumni power back in the 19th century. The written word cannot do justice to her inimitable style and anecdotal flair, but the research that she did in chronologizing the origins and precedents of the Harvard Medical School alumni association are of valuable interest and a proper salvo for this Alumni Day issue.

James R. Chadwick

It was on November 26, 1890 that "a meeting of gentlemen" interested in the formation of a Harvard Medical Alumni Association convened at the Boston Medical Library, in response to a call from one James R. Chadwick '71. It was unanimously voted to form an association, and a temporary chairman and secretary, Amos H. Johnson '65 of Salem and Robert W. Lovett '85 of Boston, were elected without further ado. Five months later, on April 30, 1891, a Committee of Five on Organization met, and the constitution it prepared was adopted by the membership with only slight modifications.

This first Committee of Five having completed its task so successfully, the chairman immediately appointed another. Reginald H. Fitz '64, Homer Gage '87, John A. Jeffries '84, Frederick A. Sawyer '56, and Charles E. Vaughan '63 were entrusted with the gathering of nominations for an Alumni Council. Duly formed, that body convened for the first time at the BML on May 7, 1891. It voted that a quorum of itself should be eight, and of the Association, fifteen. An Executive Committee of five was elected: James R. Chadwick '71, president; Robert W. Lovett '85, secretary; Walter Ela '75, treasurer; Charles F. Folsom '70; and Francis M. Weld '64. Its first official actions, on May 15, 1891, were to appoint a Committee of Three to report on the Medical School, to approve a list of the graduates of HMS, and to set the date for the annual dinner: June 23, 1891.

Now things were veritably underway and the medical alumni began to assert themselves. At the council's second meeting on June 19, it voted to recommend that the association petition the Overseers of Harvard University for the right to vote in the election of that august body. A committee commissioned to audit the treasurer's accounts respectfully reported that the accounts were indeed correctly and properly vouched. At that time, the Harvard Medical Alumni Association possessed a balance of $957.91, deposited in the Cambridge Savings Bank.

With such solid underpinnings and such auspicious prospects, the association was now in a position to confer membership as an honor. Eight honorary members were therefore promptly elected, six HMS graduates and two non-graduates: Henry P. Bowditch '68, Benjamin E. Cotting '37, Robert T. Davis '47, George L. Goodale '63, George C. Shattuck '35, and D. Humphrey Storer '25; Lyman of Boston and Walcott of Cambridge.

At long last, June 23 arrived and the real business of the alumni association began: drinking, dining, speechmaking — and not least of all, fund-raising. At the first annual meeting, followed by a dinner at the Hotel Vendome, 194 members and two invited guests gathered to hear President Chadwick speak. He announced to the assembly that the faculty had voted on May 16

that a four years' course of study be required of every student entering after September 1892.* This step the plucky pedagogues were emboldened to take with a paltry guarantee fund of $40,000. By comparison, the less adventurous academics on the University of Pennsylvania medical faculty required a $250,000 permanent endowment fund and a guarantee fund of $20,000 per year for five years to induce them to countenance the same innovation.

The Harvard alumni, however, were not about to let their parent school go so unbuttressed into battle. With a rousing appeal, Dr. Chadwick summoned the assembled alumni to the rescue, for the first of what would be many such occasions: "It is our bounden duty as graduates of HMS to convince the friends of medical education that our school must be aided to carry through this new measure of scholastic advancement. Our school is fortunate in being one department of the oldest and best equipped University in the country. Our country is suffering from the multiplicity of independent medical schools, established in many instances from no high motive, conducted for the purpose of making money or promoting the personal aggrandizement of their professors. The result is degrading to medical education, and inflicts upon the community a horde of ignorant practitioners . . . In conclusion, I may offer as our motto a phrase from the Talmud . . . 'The time is short, the work is great, the reward is also great, and the master presses. It is not incumbent upon thee to complete the work, but thou must not therefore cease from it.' "

Dr. Chadwick brought his remarks to a close and proceeded to read letters of congratulations from George C. Shattuck '35, Henry I. Bowditch '32, D. Humphrey Storer '25, and Oliver Wendell Holmes '36. The Autocrat's epistle read: "I send my heartiest greetings to the Association. I know the members would receive me kindly as a relic of the past, not without a certain value as a fragment of antiquity. I have long been the sole survivor of that primeval Faculty of which I became a member in 1847. In the days to which I refer, the Faculty could say of itself, in the words of Wordsworth's little girl . . . 'we are seven.' " He closed by wishing long life and all prosperity to the "Association of the Alumni of the Medical School of Harvard University." The members responded with an expression of their sincere feelings of respect, to be conveyed to these surviving senior members of the HMS faculty.

Since that first dinner of the alumni association, between 1891 and 1974, there have been eighty annual meetings, and fifty-one presidents, from Chadwick to Dunphy. What follow are a few remembrances from those years: glimpses of our predecessors in the context of their times.

In 1917 at a council meeting at the Harvard Club, arrangements for the annual dinner were discussed. On account of the national crisis and at Dr. Shattuck's request, it was decided that an announcement be made that members should not order champagne. Dr. Shattuck offered to provide beer. As things turned out, there was no annual dinner.

At a council meeting in 1919, industrial medicine was discussed, and Dr. Easton emphasized the great need for physicians in various public positions. He told of a specific instance in Washington where a physician was needed for child welfare work, at the then immodest salary of $4,000. So far, he reported, the authorities had been unable to find a suitable "man" to undertake this work.

It was at a 1926 meeting of the alumni council that the idea of "a bulletin or news sheet, published once or twice a year, and distributed to all alumni," was first suggested, to "make the graduates think of the School, and thereby keep in touch with it." The inaugural number of the *Alumni Bulletin* appeared in March 1927, with Joseph Garland '19, alumni secretary, as *ex officio* editor.

In 1930 the president of the alumni association, Frank Rackemann '12, received a letter in which former dean Henry A. Christian deplored the action of the present dean, David L. Edsall, in planning to reside in the Medical School dormitory with his new wife.

In the same year the alumni council began to put aside $1,000 a year to cover "care of poor students who fall sick."

At a 1949 meeting the problem of whether or not the alumni office should operate an employment bureau was considered. A lively discussion followed, and it was felt possible to start a bureau with little increase in the cost of operating the office.

The following year, at an alumni council meeting at the Harvard Club, president Philip D. Wilson '12 sponsored the following, which was moved, seconded and unanimously voted: "That the Harvard Medical Alumni Association establish a permanent fund." This vote appears in the record over the signature of the then secretary — J. Englebert Dunphy now past president of the alumni association!

At the annual meeting held in 1951 it was unanimously agreed to contribute an annual prize of $200 to a member of the graduating class. Its first recipient was David D. Kleiwer '51, who was also the first and only prisoner of war admitted to HMS.

The first director of alumni relations, Thomas H. Lanman '16, took office in the 1951-52 academic year. After that, alumni affairs moved smoothly and effectively until 1957, when you know who became the associate director (another first)!

Amen

* However, my father graduated in the first four year class in June 1892! — D.A.M.

The Third World as an Alternate Pathway . . . Why and What It's Been Like

by Stanley P. Bohrer '58

I do not delude myself. I have no expert opinion to give you about the many crises in American medicine today or about medical education or medical politics. Since finishing my residency on Fruit Street I have spent nearly all of my professional life as a radiologist in Nigeria. Thus, it was clear to me that I was invited here simply to talk about my experiences there. Since I could happily talk about Nigeria for this entire weekend, I asked several friends what they thought I should speak about under these circumstances. As you might expect, I got as many different answers as people I asked, each suggesting something of special interest to him- or herself, such as traditional medicine, problems of development, African art or religion, or the Nigerian Civil War.

Since it is impossible for me even to touch, in any meaningful way, on all of these and other equally interesting topics, I decided to answer some of the broader, more personal questions I am invariably asked by friends and peers and even by strangers when I return to the States: Why did I go to Nigeria? Why do I stay? What is it like? and how long will I stay?

I am sure these questions are asked by different people for many different reasons and I think some of the people are also saying: "Stanley, you have veered from the expected path usually followed by Harvard Medical graduates, explain yourself." It is interesting that those who follow the main paths are not usually asked to explain themselves. Nevertheless, I hope all of you, at least privately, have asked yourselves such questions: Why am I doing what I am doing? Is it really what I want to continue to do?

Why did I go to Africa? is the easiest question to answer. After finishing my specialty training with a year in London, I was simply offered the opportunity to go to Nigeria for six months to help a colleague who was shorthanded. Sylvia and I looked upon this as a chance for an exciting work-holiday, an interlude before continuing again on the main path I had been prepared for.

Why then did I stay? There are many different levels of involvement for an outsider in a foreign culture. At one extreme is the so-called "world traveler" who hops from Rome to Nairobi to Delhi and tells you, "I have now done Europe, Africa, and Asia." Several notches above this is the traveler who spends a few weeks or months in a foreign country and believes he or she really knows the country. After my first few months in Nigeria, I felt as though I knew Nigeria, and perhaps even Africa. At that point I probably could have returned to the main path, feeling satisfied with my exciting foreign travels, and I would no doubt have confidently told you, as a self-appointed expert, all about life and medicine in Nigeria.

The next few months were the critical ones for me. As I felt more at home in my new surroundings I became more interested and involved in Nigeria, in the problems of medicine and medical education, and in many aspects of their complex society. I also quickly learned to appreciate the slower pace of life. It was then that I decided to extend my contract with the University of Ibadan and stay on my alternate path for another year or so. This decision was contrary to a popular proverb that advises, "the beaten path is the safe one." It was also contrary to most of my own previous behavior. I seemed to be following the advice of one of my favorite New England poets who was also a student at Harvard. Robert Frost, in his poem, "The Road Not Taken," probably described my life at that critical juncture better than I am able to.

The Road Not Taken

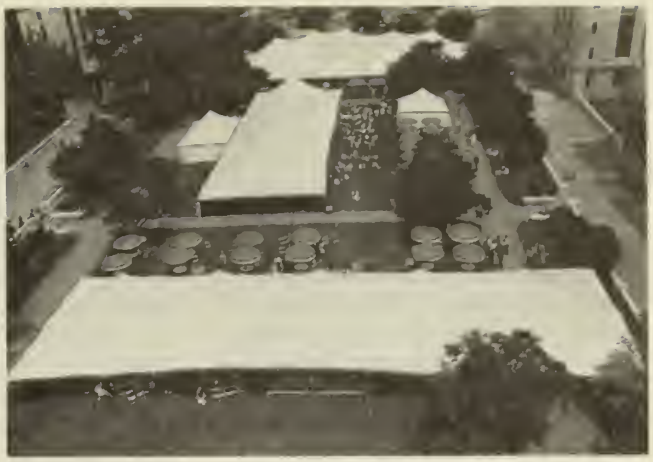
Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveler, long I stood
And looked down one as far as I could
To where it bent in the undergrowth;

Then took the other, as just as fair,
And having perhaps the better claim,
Because it was grassy and wanted wear;
Though as for that the passing there
Had worn them really about the same,

And both that morning equally lay
In leaves no step had trodden black.

Oh, I kept the first for another day!
Yet knowing how way leads on to way,
I doubted if I should ever come back.

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I –
I took the one less traveled by,
And that has made all the difference.



Nigerians love proverbs and there is another that says "if sometimes we don't get lost, there is a chance we may never find our way." I seemed to have wandered onto a path that suited me, so I continued on it. Now, more than ten years later, when my African experiences and involvement have increased considerably, I find it much more difficult to try to explain to you what it is really like living in Ibadan, the largest indigenous black city in the world with over one million people. It is not a city as you generally know cities. Ibadan has been called an overgrown village; it is inhabited mostly by farmers who work their land in the surrounding countryside. There is no large industry, no downtown as you know it, no plush theaters or shopping malls, not even traffic lights or parking meters, although both might be very useful now. Most of the houses are made of mud bricks and although piped water and electricity are available in the city, most houses have none. By our standards the people are extremely poor, most carry a heavy parasite load, and many are malnourished. But, I must say that in spite of these conditions, they do seem to be generally happy and optimistic.

Dr. Bohrer

The striking contrast between the everyday life of an average Nigerian and an American is almost impossible to meaningfully describe because most Americans lack adequate frames of reference to truly internalize the African scene. What you may have gleaned from books and movies or even a visit to South Africa or Nairobi is not sufficient. People's images of tropical Africa are incredibly diverse, with varying degrees of reality. Even much of what you hear and read from the media is simply not the whole truth. It may be propaganda or simply from poorly informed sources — often people who have spent even less time in Africa than my own initial six months. It is, however, encouraging to see more and more Americans becoming aware of and genuinely concerned about the third world.

What is it like — living in Nigeria? For me, there are many different attractions. In 1966 I described some of the interesting aspects of traditional African medicine in an essay printed in the *Journal of the American Medical Association*. At the other extreme, in the teaching hospitals, a unique situation exists with the availability of modern methods to explore the existing medical milieu, not only the parasitic and infectious diseases so common in all third world tropical countries, but also the common occurrence of diseases that are rare in our society such as Burkitt's lymphoma and hepatoma, and the rare occurrence of diseases common in the western world such as ulcerative colitis and coronary artery disease. The situation provides a natural setting for exciting research. Sir Thomas Brown clearly expressed the importance of this when he said: "Nature discloses her secrets most readily when she manifests herself in natural yet exceptional ways. It is for this reason that more extensive studies into some of the tropical areas in Africa may be more profitable for research workers than the thrice ploughed fields in temperate climates. Only the surface has been scratched in this field laboratory. There are still rich seams to be mined." Some of these seams are now slowly being mined at the six medical schools in Nigeria and more than twenty in Africa.

The constantly challenging aspects of medicine and research are certainly a major reason why I continue to enjoy living in Nigeria. The need of the third world for medical personnel of all types and the satisfaction one gets working there is another. I begin to wonder when my American colleagues tell me there is a shortage of doctors and radiologists in this country when, in fact, each of the major teaching hospitals in Boston probably has more radiologists than there are in the whole of Nigeria for its seventy to eighty million people, and Nigeria is better off than the other black African countries. Certainly the word "shortage" must be recognized as a relative term.

But it is not just medicine that attracts me to Nigeria. There is a continuous variety of other exciting and stimulating

experiences. Some are associated with living in an international atmosphere at the University of Ibadan. Among other things, this has broadened my entire outlook and it has given me a new perspective for viewing my native country. Then there are the Nigerian people themselves, their art and crafts, their ancient ceremonies and festivals, and now, the dichotomy between the old and the new as affluence and development enter the scene, bringing new problems along with any benefits. The western world is just beginning to appreciate the complexity and sophistication of the so-called "primitive cultures of the world." They have intricate and effective social systems quite different from our own. Their native law is different. Marriage, politics, religion, and even their values and morals differ from ours. In the past, their social organization based on the extended family group seems to have fulfilled most of the universal needs of people. Crimes like assault and robbery were rare and other social problems like alcoholism and simply loneliness, so common in our nuclear family society, were almost unheard of in African villages. Now, unfortunately, this same extended family structure creates new and difficult personal problems for many individuals as education, increased mobility and urbanization take place in a developing nation.

To read about an ancient culture is one thing; to actually live within it at an exciting time is quite another. Of course my acceptance into their society is something less than one hundred per cent. My white face is an obvious giveaway — I am not and never can be a native. But over the years, as one gradually becomes more involved with individuals and the society, one does become accepted in some limited ways.

I feel a little like Thoreau, another Harvard graduate, describing in great detail the alternate path he chose. Some of his words about life at Walden also summarize my feelings about living in Nigeria. He said: "I had this advantage, at least, in my mode of life, over those who were obliged to look abroad for amusement . . . that my life itself was become my amusement and never ceased to be novel. It was a drama of many scenes and without an end. Follow your genius closely enough, and it will not fail to show you a fresh prospect every hour."

I hope these few glimpses of my own life and feelings and of Nigeria can give you some small idea about why I chose to remain there. However, before any of you, who may now think the third world suits you too, push aside your microscopes to rush off to Africa, it is only fair to remind you that I have not spoken about the many problems and frustrations you may meet living in a tropical developing country. For instance, are you up to returning to natural solar energy to dry your clothes in the backyard? It is pollution free, I might add. More seriously, depending on where you go, you may have to give up the 'tele' as a source of instant entertainment, and also be without piped water, electricity, and a telephone. The local parasites may take a liking to you and you may dislike the warm, humid climate. You will probably have to make a significant financial sacrifice, and the country's political actions and decisions can affect you and your future at any time.

The third world is not the right place for everyone. Each individual must warm to his or her own fire. Only you can weigh all of the factors, the positive against the negative, using your own scale of values, and decide which path is the right one for you to follow. If you are thinking of going because of some guilt feelings about "the white man's burden," please do yourself and the third world a favor — stay at home.

If any of you or your friends or children do decide to give the third world a try, my words of advice are few and simple. First, find out all you can about the country you are going to, preferably from someone who has actually lived there for more than a few days. When you do get there take plenty of time to just observe and learn firsthand what it is all about; then, work within the framework of the country and culture you are in. Consider their needs and desires, their strengths and weaknesses; they surely will be different from your own. Too often Americans see the rest of the world in their own image. Do not just directly transport your own culture and way of doing things. Be selective, flexible, and adaptable. So-called "experts from abroad" with no appreciation of the local situation are neither helpful nor appreciated. And finally, do not expect short term miracles. You will gradually learn what you can and cannot do and what you should and should not try to do.

The final questions that I am repeatedly asked are, how long will I stay? where is my path leading? and what are my plans for the future? My answers have not changed much since I first decided to stay in Nigeria. It is not what is at the end of the path that seems most important to me, rather it is what one does and experiences along the way. In this rapidly changing world of today, I prefer to plan and live each year or two at a time. A lot has changed in the world and in Africa over these past ten years and change is continuing at an accelerating pace. I still believe and follow what I have answered for all of these ten years: as long as my life in Nigeria continues to be stimulating and satisfying, I will stay on my alternate path for another year or so.

From Harvard to Walpole Prison (and Back)

by Curtis Prout '41

It may seem inappropriate on this joyous occasion to talk about prisons, but, perhaps, a brief guided tour of prison medicine will be mildly educational. This is an entirely different kind of medicine from that which we have been taught. The intellectual accomplishments of the faculty and students at Harvard Medical School are admirable and even essential to the future of American medicine; on the other hand, to go in the same day, as I have sometimes done, from grand rounds at the Peter Bent Brigham to the sick line at Walpole Prison or the hospital at Norfolk Prison, and to try to coordinate these two experiences, is shaking and bewildering. It is, in fact, the ultimate expression of the dichotomy that constitutes modern medicine. In the course of working or visiting in many prisons, I also investigated most of our public health and mental hospitals and one for the mentally retarded, so I think I can speak about a fairly large segment of our population.

There is a story that explains the present interest in prisons. The parents of a four year old boy were extremely worried about him. He had shown all sorts of promise. His growth and development were normal. He was a paragon in every respect except that, so far, he had not uttered a word. One morning, he took his first mouthful of oatmeal and said, "My God, that cereal is hot today!" His mother could scarcely contain her astonishment and said to him, "If you could speak so well, why haven't you said anything before now?" to which he replied, "Well, up to now, everything's been going all right."

Evidently, until the riots of Attica, the American public thought things were going all right in the prisons. The good prison was the quiet prison. Precisely the same circumstances hold true for large mental institutions, hospitals for the mentally retarded and those for the incompetent aged. These systems have many similarities and, actually, much overlap in their populations.

How did I get into this lugubrious but fascinating field? After Attica, there were riots in Massachusetts's prisons, as elsewhere. Appropriately enough, the chief complaint in prison riots is a cry for justice. Better medical care, however, is a more tangible item easier for the public to understand, and for the government to investigate. The governor of Massachusetts appointed a committee that produced an excellent report with a number of recommendations. Principally, they concluded that prison medical care should be taken away from the department of corrections and placed under the department of public health. This parallels moves made many years earlier in the federal prison system and parallels moves now underway in many other cities and states. Unfortunately, this is an unrealistic expectation, as departments of public health are moving away from direct patient care and more into regulatory functions. Nevertheless, Massachusetts made an application to the Office of Economic Opportunity for a pilot study with me as director to set up a model health care program. A small grant was awarded in the summer of 1972.

For two and a quarter years, I worked full time in the prisons and out of an office in Boston near the departments of public health and corrections, but totally independent of them. We were, therefore, independent but sadly had no "clout." I was the only physician on a project staff that varied in number from five to twelve. Much was expected of us which we had neither the money, personnel, nor legal right to carry out. The infighting and chaotic clashes of ideologies and attitudes was both an education and a shock to me.

Increasingly, conditions in prisons all over the country have come under attack. I have a file drawer full of studies made by committees on medical care in prisons and they all share some uniform features. The authors tend to be drawn from academic and public health ranks and they are stunned by what they find. These two groups have, perhaps, the least experience with the delivery of medical care to an underserved population. Seldom have the investigating committees talked at length with the prison doctors and nurses who have been on the job and who actually face the day to day problems. More important, none of these studies have come to grips with the problem that basically, prisons are the way they are because that is what the public wants.

One damaging series of attacks on those who are actually doing the work needed in prisons has been on the foreign trained physicians who cannot meet the standards that we expect of our well trained American doctors. These foreigners are being pushed out of our prisons and mental hospitals. This might be all right if we had well trained American physicians willing to replace them, but, of course, we do not. We should acknowledge our gratitude to this underpaid and demoralized group that has been doing a lot of our dirty work for us.

The situation, in fact, recalls a rumor current during World War II. It concerns

the paratroopers of one of our co-belligerents. The complement of one of their parachute planes was said to be eleven men: a pilot, co-pilot, navigator, a parachutist and seven men to push him out the door. The average prison doctor feels about like that parachutist.

Who are the prisoners? There are about 400,000 of them in the United States, approximately half of whom are convicted and are serving long sentences ranging from a few months to life, the average sentence being somewhat over two years. They are male by a ratio of 20/1 and, in Massachusetts, by a ratio of 30/1, so if I speak of the prisoners in the masculine gender, my bias is only statistical. They are young, mostly in their late teens or early twenties, disproportionately poor, black, or Puerto Rican. The evidence is strongly suggestive that most prisoners in the United States are not below average in intelligence and, in fact, they may be above average. They are verbally skilled, but the incidence of dyslexia is remarkably high. The prisoners tend to come from fatherless families where alcoholism is extremely frequent and where acting out of various aggressive and sexual drives is the accepted pattern of behavior. Many of them come from a relatively small social group. A young inmate once told me that when he first went to our maximum security prison at Walpole, he already knew one-third of the inmates and knew of another third. Prison inmates are less than one-tenth of one per cent of our population; there are three thousand people in the state and county prisons in Massachusetts.

Dr. Prout

The largest group of arrests is associated with sale or possession of drugs, yet the substance most commonly associated with criminal behavior both before and during incarceration is alcohol.

Mark Twain, as usual covering a lot of ground in a few words, said: "It could probably be shown by facts and figures that there is no distinctly native American criminal class except the Congress." These patients are a group who are, in fact, in prison because we do not know of any other way to handle them.

This was not always so; there were no large prisons or mental institutions in colonial America because mankind was considered inherently evil. An offender was therefore given a short, painful punishment and told to mend his ways; if he did not heed that warning, he was hanged. In the nineteenth century the current outlook, which is usually described as liberal, came into being, namely that mankind is inherently good or capable of being good and that only institutions are bad. The large prisons and asylums were actually established to withdraw these unfortunates from an evil world and put them together in a large, isolated place where they could repent their sins and be subjected to good moral influences. Prisons do not correct or reform.

Why is medicine inside prison walls different from that in the outside world? In the first place, a patient's medical needs, no matter how urgent, are always secondary to the laws of the correctional security system. The superintendent of a prison can, and frequently does, overrule the medical facility.

If we assume that seventy to ninety per cent of a medical diagnosis is arrived at by the medical history, deficiencies immediately appear in prison. First, the patient, like the college student, assumes that if the doctor were any good, he would not be working there in the first place. Second, the inmate-patient has a vested interest in not having any derogatory information appear in his medical record. The inmate is not going to talk about venereal disease, sexual aberrations, drug habits or aggressive impulses or thoughts, because confidentiality as we know it does not exist either by law or by custom. Very few prisons have complete medical records because the patient, his friends, his enemies, and the guards all have a stake in getting hold of this record. The history is further obscured by the fact that the inmate has many possible secondary gains in mind. He may want to get out of an unpleasant cell block; he may want to be transferred to another institution; he may want a favorable recommendation for parole or commutation. Above all, he may want drugs, especially addictive substances. The pressure on the new or inexperienced physician to prescribe is enormous and the ingenuity of the patients in asking, even demanding such products is extraordinary. One Nembutal capsule given to a prisoner and secured in his dry cheek pouch until he leaves the dispensary has a resale value in Walpole Prison of roughly five dollars. For all of these reasons, the medical history cannot be relied on. Inmate medical clerks are worse than none at all; they have the power of electing who sees the doctor, slanting the history, and even recommending treatment. Furthermore, the conscientious inmate record clerk is himself subject to threats, harassment, and blackmail.

Proceeding from the history to the physical examination, we find that the numbers of patients (anywhere from twenty to three hundred a day according to the prison), the lack of privacy, the presence of a guard, and the usual lack of the simplest routine diagnostic equipment are further handicaps.

As for the laboratory, very few prisons have adequate equipment. When we installed medical corpsmen at Walpole and Concord Prisons, at least they were able to collect urine specimens, do simple dipstick tests on them, draw bloods and send these specimens to a local hospital or laboratory. Unfortunately, prison systems are chronically bankrupt. Eventually, even the kindest

of laboratories and hospitals refuse to work without money. In the only hospital we have in the system there is a fairly simple laboratory that would have been adequate for a community hospital thirty years ago. It has one underpaid and unsupervised civilian lab technician working part time. The inmate lab technicians show a notable lack of enthusiasm for working and learning. The reason for this is they can be paid, according to state regulations, only fifty cents a day. In addition, the possibility of training in laboratory work for later employment is scarcely appealing to a man serving a life sentence. In any case, we were unable to provide sufficiently broad experience to warrant certification for the technicians.

One more obstacle: we are all used to the consultation system in outside practice, perhaps too much so. The prison physician usually has great difficulty in getting any of his specialist friends to come to the prisons, which have characteristically difficult accessibility. In most states, there is little or no money to pay consultants. We are lucky here to have a few people such as our own Bart Quigley who goes out to Norfolk and Walpole seeing patients in consultation and together with his orthopedic residents doing a great deal of surgery.

The best prison physicians are real general practitioners; they have to be. In taking the sick line or making rounds in the prison hospital I have often been forced to make decisions in matters in which, under ordinary circumstances, I would have felt a specialist absolutely essential.

If you have not heard enough already, let me tell you two other handicaps under which the prison physician must labor. The first is the extraordinary slowness with which anything gets done. To send a patient to an outside hospital with, for example, a penetrating wound of the heart (not a rare situation) requires the physician first to ascertain the nature of the emergency. He must then get permission of the superintendent to transfer the prisoner, he must find a hospital willing to accept the prisoner, he must find an ambulance (which usually has not been paid for the last trip). The ambulance must be carefully inspected before entering the prison yard to be sure that it is not carrying in contraband and again after the prisoner has been loaded in to be sure that no unauthorized person leaves the prison. Our figures are that the fastest this can be done is twenty-five minutes and it is usually nearer one hour. This requires steady nerves and considerable self-reliance on the part of the medical personnel.

What are the diseases the prisoners suffer from? In general, since inmates come from the group that has the least and poorest medical care, the variety and severity of disease might be expected to be considerable. The statistics are by no means clear. The population is in the healthiest age group. There is some increase but by no means an epidemic increase in hepatitis. The number of positive tuberculin reactors and inmates with open tuberculosis is not at all high, probably no higher than that of a comparable group outside the prison. Gonorrhea is extremely common, alcoholism is equally common. In most prisons an inmate who has access to money or favors to give can easily get alcohol and even drugs. Drug addiction and abuse in prison is a problem proportional to the looseness of control. There are no truly drug-free prisons but there are many in which the "drug problem" is not a major medical worry. For the cardiologists here I am afraid I have no precise figures, but the incidence of hypertension among the population at Norfolk Prison, which is about forty per cent black, was unexplainably low. A survey last year showed only two previously undiscovered cases of serious hypertension in a population of 700 men. The incidence, however, of heart murmurs appears to be considerably higher than that outside although it is not possible to collect a cohort group for comparison. The incidence of headache is lower than that seen in office practice, particularly if the physician develops a reputation for not handing out prescriptions freely. There is an enormous waiting list for upper GI series so that I cannot give you exact figures, but the general impression of all prison physicians is that peptic ulcer is much more common in prison than outside. Again, remember that we have no valid studies of a cohort group.

For those interested in surgery there are, of course, acute abdominal emergencies in prison. The more dramatic surgical presentations are stab wounds and skull fractures. It is a tribute to the Massachusetts General, Peter Bent Brigham and University Hospitals that in the epidemic of stab wounds of the chest at Walpole two years ago, of the fifteen prisoners who reached the outside hospital alive all made a complete recovery. The favorite weapon is a sharpened welding rod carried inside one pant leg. The level of tension in a given prison can some-

times be gauged by the number of men who seem to be walking without bending one knee.

There are some other peculiarities in prison medicine. Gynecomastia is surprisingly common. Chronic users of opiates tend to gynecomastia apparently because of interference with the degradation of prolactin. Self-mutilation, particularly among young men of Latin extraction, is a curious phenomenon that is surprisingly frequent. Suicide, on the other hand, occurs usually only in those who are awaiting sentencing. The suicide rate of those in long term prisons after sentencing is considerably lower than that in the outside world. For the psychiatrists among you, I can say that the situation is a nightmare. Being in prison is, of itself, a cause for psychosis, so treatment of psychoses and of aggravated neurotic conditions inside the prison walls is most unsatisfactory. Violent behavior after imprisonment is an infrequent but real problem. In individual cases, it is hard to predict. There is evidence that physical violence is rarely due solely to organic disease of the brain. Studies by Sweet, Ervin and others suggest, however, that violent acting-out may be due to a *combination* of cultural factors, neurological damage, and psychological problems.

What does it take to be a prison physician? Toughness, willingness to make decisions in the face of inadequate evidence, and enough ego strength to withstand the stigma of working with the group that society has placed at the absolute bottom of the heap. In short, to be a full-time prison doctor you have to be a little crazy.

No one can or should, for long, be a full-time prison doctor. One obvious remedy is to have smaller prisons nearer big hospitals or medical centers, and have a team of physicians rotating through the system. In my experience, women physicians are temperamentally better suited than men. Female nurses have almost always been well received, well protected, and extremely effective deliverers of medical care. Our biggest contribution, perhaps, was in extending the use of paramedical personnel in the form of medics. All of our medics were military veterans; despite the miserable pay, which is less than that of the guards, they showed resourcefulness and devotion to duty and, above all, they enjoyed their autonomy. We also found that medical students worked well in prisons if properly selected and when supervised; several medical students found it a great learning experience.

There are two other special problems worth mention. The first concerns the use of prisoners as volunteers for human experimentation. This is currently most unfashionable and, in fact, has been brought to a halt in Massachusetts. The authorities, however, did not bother to ask the patients what they thought. We had worked out with them a set of guidelines for informed consent in human experimentation more stringent than the federal guidelines. Inmates are a group who desperately need a chance to build self-esteem; they also need a legitimate opportunity to earn cash. Whether or not they can give fully informed consent is, of course, open to debate, but who can?

One other problem is that of blood donation. The American Red Cross considers that prisoners who get time off their sentence for giving blood are in effect being paid, and, to our distress, has adamantly opposed prisoners giving blood.

Here are some realistic recommendations for prison health care:

- Prisons must be made much smaller so that they can be integrated back into the community. Under these circumstances, local hospitals and doctors would be more willing and able to help part time.
- We should return to universal service, so that for all the tough jobs in our society, not just in the prisons, we would have a rotation of young people with a fresh outlook.
- The use of paramedical personnel should be greatly expanded. We should make it possible for an inmate to give a medical history in confidence and for the medical record to be kept segregated.
- The people who do the tough and unappealing jobs in our society should be given more rather than less prestige and they should be paid better than their colleagues.

To conclude, it is a long way from Harvard to Walpole Prison. It is a hard journey from which we can all learn a lot, and if enough people make the trip it could become a shorter one.

Sex at Harvard

by Evelyn D. Waitzkin '50

Musing on a possible catchy subject, I was determined *not* to talk about women in medicine, or the problems or experiences of women in medicine. I had left social work wanting to find the tools and the means for dealing more basically and effectively with social and emotional problems, and impatient with the frequent discussions of social workers of that era questioning "are we, or are we not, a profession?" The same uneasiness is evoked by present considerations of the problems of women in medicine.

Pressed for a deadline, I chose the subject "Sex at Harvard," thinking about it loosely, if I may be forgiven for so doing, because of the many aspects it presents to me as a general psychiatrist and especially because of my particular interest and involvement in the recent course on human sexuality.

But, like a moth hovering about a flame, I kept coming back to "women in medicine," and decided that this, too, could be considered an aspect of "Sex at Harvard." I must admit that this excludes much. The varied expectations and fantasies as to what I would say about this subject, expressed to me by colleagues, would themselves make for an interesting talk.

The registrar's office informs us that the class of 1949, first to admit women to this school, at its entrance comprised 112 students, of whom 13 were women. They graduated as a total of 141, of whom 12 were women. Next year, my own class admitted 6 women in a total class of 113, graduating 4 in 1950. The present first year class admitted 54 women in a total of 165. This is a gratifying direction.

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The Joint Committee on the Status of Women was established to deal with the problems based largely on combining femininity and medicine. Perhaps the restless uneasiness I feel about this subject is that I have never viewed it as strictly "female trouble." It involves men equally — their perception of themselves as men, their view of women as perceived by men (as well as by women), the impact of career on personal life for both men and women, and the modes of dealing with child bearing and rearing as a joint concern.

I am hopeful that the increasing ratio of women to men will bring to both a fuller, broader, more complete understanding of and response to each other's talents and potentialities. In a field where, at first glance, one might not think the same questions of male-female relationships pertain, it is provocative to consider the comments of Clive Barnes, drama critic for the *New York Times*, on the ballerina Maya Plisetskaya: "Plisetskaya is an original, a totally free spirit. She is her own woman and certainly her own dancer. This is what makes her important . . . She is a ballerina who always treats men as equals. Most ballerinas treat them as partners . . . She has sought to portray the eternal female. Not, indeed not, as a sex object (even though Plisetskaya has more sensuousness in a minor finger than most women have sensuality in their entire bodies), but simply as a woman."

In the climate of greater assertiveness and consciousness-raising that leads to developing opportunities for women, all of the ways in which men and women relate to each other are subjected to more open scrutiny. Human sexuality has clearly become an area of frank concern, with troubled or dissatisfied males and females seeking help, acknowledging that intuition and instinct do not solve everyone's problems. People identify doctors as a primary source of sexual information and counseling, but as William H. Masters has pointed out, "Physicians probably know no more and no less about the subject than do other college graduates. They share most of the common misconceptions, taboos, and fallacies of their nonmedical confreres."

At present, nearly all US medical schools offer courses about human sexual behavior and sexual dysfunction, a marked change from none before 1954, and only thirty as recently as 1968. Here at Harvard Medical School, in response to requests from students, Dr. Leon Eisenberg, head of the department of psychiatry, organized a course in human sexuality four years ago as a regular part of the curriculum placed in the fall semester of the second year. It has consisted of a series of lectures followed by smaller discussion groups usually with two co-leaders. A camel and bibliography have been supplied each year. The department of obstetrics and gynecology has always been involved and at times urologists and internists have participated. The topics have been adjusted from year to year. Films have been used within the lecture or at separate hours. The sexual knowledge and attitudes questionnaire designed by Dr. Harold Lief at the Uni-

versity of Pennsylvania and adapted by Drs. Joanna Gardner and Carol Nadelson was administered before and after the course.

My relationship to the course has been a small one, namely that of discussion group leader or co-leader for the past three years. I found the experience most rewarding and instructive. I was especially impressed by the deep interest and frankness of the students. Although the course questionnaires returned by about thirty per cent of the class were hard to assess because of their varied responses and preferences, the consistent message was that the course should be developed more fully and provide more understanding. When my group heard that the course might not be given next year they expressed strong disappointment, saying that it was one of the few opportunities provided to talk about feelings, attitudes, as well as factual insights in this vital area. It would seem that primary care physicians have an obligation to have enough information, experience, and self-awareness to deal with basic sexual problems, and to refer difficult ones.

"Learning about sex is different from learning about anatomy, chemistry, or even clinical medicine," as Dr. Harold Leif says, "because the feelings of the student are bound to be involved in a more intense and private way." Students come with such different backgrounds, it is difficult to know how to design the course. One of the goals is to stimulate an awareness of assumptions and expectations, and how these may mold treatment of patients. Although everyone is sexual, differences exist related to class, culture, orientation, and complex emotional and moral factors.

Sensitive moral issues are present with such problems as abortion, treatment of venereal disease, teenage pregnancy, rape victims. What is our obligation toward a patient who does something against our own personal morality? An example comes to mind of the young teenager who sought contraceptive advice from the family physician and was assailed with such a harsh lecture of refusal that she sought no further and ended with an unwanted pregnancy that posed more difficult problems. Or the highly knowledgeable infectious disease expert who told me he would not want a philandering businessman who contracted venereal disease on his travels to come to him for treatment.

I am told that there are administrative problems, beyond my experience, in the teaching of an elective course. Recruitment of voluntary faculty for large blocks of time, when the number of students is unpredictable, is not easily arranged. The timing of the course at a difficult hour mitigates against attendance. Placing it early in the second year, with little previous clinical experience, raises questions about the students' readiness for this material. Some students avoid it because of anxiety, which might be lessened at a later stage of training. Interdisciplinary courses are rare in the Medical School, and this is a good example of one that needs to be, but questions remain as to how best to effect such an arrangement.

In view of my experience as a psychiatrist as well as the unquestionable positive response and need of the students with whom I was privileged to learn, I very much regret that the plans for offering the course as an elective this June did not work out and that the future plans are not yet settled. I hope that the Medical School will see this as a necessary learning experience for primary care physicians that should be supported and developed.

Spreading the Specialty Spectrum

by Ralston R. Hannas, Jr. '50

Dr. Hannas

The theme of this presentation can perhaps best be summed up by the aphorism, "if you can't lick 'em, join 'em." In developing two new in-breadth type specialties, in an order of established in-depth type specialties, we have had to do this many times.

During twelve-and-a-half years of rural general practice in southwestern Oklahoma, there was plenty of opportunity to observe my colleagues dying or leaving to join other specialties and not being replaced. This was not a rural phenomenon; it was also taking place in urban areas all over the country. In 1960 approximately thirty-seven per cent of the graduating medical students were choosing general practice. By 1965 this had dwindled to less than ten per cent. In my part-time activities in continuing medical education for the Oklahoma State Medical Association, and in undergraduate teaching for the University of Oklahoma Medical School, it became evident that unless we changed the rewards system, we would soon be producing physicians who could handle only one to ten per cent of the problems patients brought to them, and would thus be aggravating our physician shortage and the maldistribution of physicians.

The reward system, of course, involves pay, personal satisfaction, and status. General practitioners had adequate pay because they worked long hours and saw many patients. They had personal satisfaction running out of every orifice because of the types of problems they saw and their ability to deal with almost all of them. They had status with the patient, but almost none in the profession. To get this status in the profession, they had to earn it in the same structure already occupied by the other specialists.

In early 1965 I elected to take a full-time position on the staff of the Academy of General Practice in Kansas City as Director of the Division of Education, at a time when that organization was beginning its most serious efforts towards establishing some kind of certifying board for its members. As secretary for the four major committees involved in this effort, I thought it was a once-in-a-lifetime experience. Five years later, however, with the American Board of Family Practice having become a reality in February 1969, I was engaged in the development of a second in-breadth type specialty, this one emergency medicine, and this time, as a member and later president of the American College of Emergency Physicians.

In developing each of these new specialties, it was first necessary to formulate the concepts, and help was obtained from the Western European and Australian literature and from the work of some of the pioneers in this country. We studied the evolution of the other specialties and found that there were identifiable steps which, though they did not always occur in the same order, and often occurred simultaneously, could at least be well plotted. Whereas general practice had provided continuity of care for disease and illness, it would be the duty of family medicine to provide continuity of care for patients and families. Emergency medicine would provide only initial and episodic care, providing no continuity.

The first step in the development of any specialty is the definition of the content of that specialty. All physicians use the same skills, techniques, and procedures but it is how they use them that determines the content of each specialty. For some, such as pediatrics, age was the main criterion. For ob-gyn it was sex. For some it was an organ system; for others, areas of the body or even orifices — as has been remarked, there was an opening for everybody. The content of general practice had never been defined so the initial step was to define the content of family medicine. This was done in a publication entitled, "The Core Content of Family Medicine," and though this document has been much maligned, there has been very little improvement on it.

In emergency medicine our content is defined by the public. The patient decides what an emergency is, not the doctor, the nurse, the receptionist, the ambulance driver, or anyone else. Therefore, to outline the content of emergency medicine, we simply went to our records over the past several

years, categorized them, established goals for each category, listed the patient's needs or problems, and established the skills and techniques physicians must have to meet patients' needs. This has been well recorded in a document entitled, "Report on the Conference on Education of the Physician in Emergency Medical Care," sponsored by the Council on Medical Education of the American Medical Association, and held in July 1973.

The next step in the evolution of a specialty is the development of graduate training programs — the residencies. This, of course, involved writing essentials or standards for the AMA Green Book, having them approved, and setting up approval mechanisms. Though this may sound easy, it is often a long and involved process. For family practice, the impetus of the Millis, Folsom, and Willard Reports of 1966-67 helped to goad the Council on Medical Education into action.

Essentials for emergency medicine residency have been in the mill for about four-and-one-half years. The Council on Medical Education got down to work in earnest, however, in the last year after the House of Delegates of the AMA directed the Council to expedite the adoption of essentials and the establishment of an approval mechanism.

One of the big problems in designing the new residencies was to eliminate the profuse and diverse rotations that helped kill the general practice residencies. Except in the first year of graduate training, when in-depth exposure to some of the other specialties is advisable, family practice must be learned in a family practice set-up or model, and emergency medicine must likewise be learned in the emergency department. There are some two hundred or more family practice residencies at present and this year there were twenty-eight residencies in emergency medicine. This number is growing rapidly. One of the obvious problems in these residencies is to find accomplished practitioners of these new specialties to teach them. Some of the poorer residencies are those taught by would-be academic opportunists who have entered the field without experience in the specialty involved.

The next step in the specialty evolution is the adjustment that medical schools make to produce a physician qualified to enter the residency training and, eventually, the development of departments in each specialty. Undergraduate curriculum in emergency medicine should teach basic emergency procedures that all physicians ought to know, thus replacing what was formerly taught as first aid. A clerkship in a busy emergency service is also advisable.

Department development is a slower process because a new department is often a threat to the established departments. It means someone might have to give up time, space, people, and even money. Family practice departments were fertilized when Congress allotted government funds for medical schools in this area providing that they had family practice departments. Needless to say, that was a big boost for family practice departments. There are at present two departments of emergency medicine in medical schools and this number will grow as the specialty matures and as the need arises. If we fail to meet public expectations in terms of providing adequate numbers of emergency physicians, we can rest assured that Congress will also appropriate funds for emergency medicine departments to train the necessary number of physicians.

The next evolutionary step is that of setting standards, and it appears that in medicine the main way we know to do this is through the establishment of certifying boards. An AMA publication entitled "Essentials for Establishing a Certifying Board" is indeed a steeplechase to which added hurdles are thrown in the closer one gets to the finish line. The certifying board in family medicine was established in February 1969 after meeting all the requirements in the steeplechase. An emergency medicine board will be established after all of the requirements are met (and there are only two remaining) and then approval will be sought. The approval mechanism itself takes a year and involves the American Board of Medical Specialties and the Council on Medical Education, with the new Coordinating Council and the LCGME as probable added starters. Whenever ten thousand or more physicians are practicing in a particular specialty area, it is absolutely necessary that standards be established and that these physicians be required to meet the same professional standards as other physicians delivering health care to the public.

The next evolutionary step is the development of examinations, to be certain that the standards are met. Family practice chose the National Board of Medical Examiners as its consultants and a committee of ten general practitioners helped put together the first family practice exam. It was very practical and followed the format of Parts II and III of National Boards to a certain extent. Emergency medicine has chosen as its test consultants OMERAD (Office of Medical Education, Research and Development) of Michigan State University. Present plans call for a first day of testing the perceptive and cognitive skills with standard multiple choice questions, patient management problems, and pictorial and chart-type questions. The second day will consist of sessions measuring the manipulative skills with models such as the Mini-Anne, Ambu-Anne, and so forth, and the affective skills with simulation techniques. This will be a truly performance oriented exam, as indeed is the specialty itself. The logistics are difficult but can be solved. Emergency physicians have the unique problem of establishing in three to five minutes a doctor-patient relationship with a patient they have never seen before, and will probably never see again. They must not lose their cool. We think we can measure the skills necessary to identify competent emergency physicians.

To insure that the standards are maintained, the next evolutionary step is the development of continuing education programs. All of us remember the leadership of the Academy of General Practice and its successor, the Academy of Family Physicians in first establishing continuing education requirements as a requisite for membership. The College of Emergency Physicians has followed this lead completely and both organizations are also on record as endorsing recertification periodically. Each specialty has had numerous successful national and state level scientific assemblies and the College of Emergency

Physicians now has a self-assessment test in use by its members. Peer review is a way of life for those of us in emergency medicine as we get such things as daily score cards from the radiologist and cardiologist and feedback from our follow-up physicians.

The last step in the evolution of specialties is the development of research programs that contribute to the overall body of knowledge of medicine and the content of the particular specialty. For family medicine we feel the initial emphasis will be on the delivery of health care and the increased and improved involvement of the behavioral sciences in medical teaching and practice. We also think there is a challenge to this specialty to develop improved rewards for physicians who provide health maintenance and preventive medicine for their patients and families. It may be fifty years before we see the impact of the behavioral sciences in this area.

For emergency medicine the immediate challenge is the development of the emergency medical system that is now reaching out and treating patients in their homes, at the scene of an accident, on the road, or wherever the acute episode needs immediate care. Through telemetry and the training of such physician extenders as emergency medical technicians-ambulance and their advanced counterparts, the paramedics, we are now able to respond in a matter of a few minutes with life-saving measures for cardiac, traumatic, and other life-threatening conditions. Emergency medicine is also developing different clinical approaches to some of the common problems which, though not life-threatening, may be urgent in the emergency department. We often have very little knowledge of our patient's history or background and the available follow-up is quite unpredictable. Hence, different approaches are necessary from those used in a family practice or specialty office type practice. A bibliography is gradually developing and there are four or five textbooks in preparation at this moment.

Throughout all of this specialty evolutionary process the catalysts are the various specialty organizations. For family practice it was first the AAGP, later the AAFP, the Section on General Practice of the Scientific Section Council of the AMA, and the Society of Teachers of Family Medicine. In emergency medicine it has been the American College of Emergency Physicians; a new Section on Emergency Medicine in the AMA Scientific Councils; the Federation involving ACEP, the University Association for Emergency Medical Services, and the Society of Critical Care Medicine; and now the newly organized Society of Teachers of Emergency Medicine. Much committee and individual work lies ahead in both fields, but the goal for each of them has been to produce physicians who are capable of treating large numbers of patients and will thus help medicine meet public expectations.

Neighborhood Health Centers

by Isaac M. Taylor '45

I was originally asked to talk about the regionalization of health services, something I have been connected with for ten or fifteen years. For most of that time I was involved in the struggles of the University of North Carolina School of Medicine to bring regionalization to the provision of health services in that predominantly rural state. Then I came to Boston and worked with the Tri-Stage Regional Medical Program, which is the reason-for-being of the Medical Care and Education Foundation, of which I am still a staff member. I am rather discouraged at this point about regionalization because I think it is extremely important, but we are moving very, very slowly.

Therefore I decided to speak not about regionalization, but about something that is perhaps an important first step in it — the neighborhood or community health center. I have had relatively little experience in this area, working for only about six months in my present position as medical director of the North End Neighborhood Health Center. But like Dr. Bohrer's, my experience may be somewhat unfamiliar to some of you, and therefore of interest.

I first became familiar with the concept of neighborhood or community health centers while still in North Carolina. You will remember that in the late '60s and early '70s, the Office of Economic Opportunity was interested in the possibility of affecting our social institutions broadly, through the provision of health services. They came to the medical school at Chapel Hill and asked if we would be interested in the establishment of rural community health services, in an attempt to meet the needs of the people who live in three rather small and medically deprived communities within a forty to fifty-mile

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radius of the school. We saw this as an opportunity to meet our aspirations to extend the influence of the medical school into the communities of the state and hopefully to improve the quality of medical services. That work got underway while I was still in Chapel Hill, and has developed since. In our developing community efforts, we followed the lead of our neighbor institution, Duke University, in using rather highly trained physician extenders. Duke was one of the first to train the physician assistant; we saw the need for a physician extender and elected to organize one of the earliest nurse practitioner programs. Today, one of the characteristics of the neighborhood health centers is the use of the physician extender in meeting primary needs.

In concept, neighborhood health centers really are not anything very new. They have evolved from a long experience in trying to fill unmet needs for services in urban and rural communities. The density of the population is what mainly distinguishes the urban and the rural neighborhood or community health center. One of the common qualities of these two types is that they have grown up in areas where physician services were extremely limited. The urban centers have their roots in such organizations as the district stations of the Boston hospitals and the East Boston Aid Station of the Boston City Hospital, which now has become the East Boston Neighborhood Health Center.

The neighborhood health center movement at the present time plays a very important part in our efforts to evolve a health care system that can meaningfully meet public needs. The concept is really working now, and delivering a great deal of needed health services in a fashion that is satisfactory to the people in the community. I think it is a transient phenomenon, however; I agree absolutely with Curtis Prout that we need some very fundamental reassessment of the incentives for the distribution of health manpower, and that some kind of universal health service is desirable to provide services that otherwise would be unmet.

The North End Neighborhood Health Center, of which I am medical director, serves the Italian section of the city, which is quite unique among the neighborhoods of Boston. I remember the North End and the people who live there very warmly and fondly from my days as a house officer at the Massachusetts General Hospital, when many of our patients were North End residents. I had expected that when I went back to work in the North End some twenty years later, I would find that there had been a good deal of change; for example, that the language

barrier, which in the '40s and early '50s was a considerable problem in caring for North End residents, no longer would be present. I was quite astonished to find that, for those of us who do not speak Italian, it is still very much a problem. As the older Italian-speaking residents have died, or as others have moved out, there has been a continuing immigration from Italy, and evidently many of those new to the Boston area still settle in the North End. On Hanover Street, the main street, the language is Italian. I would judge that about fifty per cent of the patients we see do not speak sufficient English to be able to discuss their medical problems in a meaningful way. What this means, of course, is that we have to have translators available, and we make do with this indirect kind of communication.

I suppose the construction of the central artery which connects Storrow Drive with the Southeast Expressway has had some influence in preserving the identity of the community, and it certainly gives it a geographical delineation. It is not easy to walk from the North End to the rest of Boston, or the reverse way, because of that elevated highway; that defines the southern and the western extremities of the North End, while the entrance to the Charles River and the Boston harbor form its other boundaries. Alarmists in the community are saying that the culture is changing and the old qualities are being lost. But as one plunged recently into it, I can assure you that there still are very unique qualities in that neighborhood. There is a sense of identity with the neighborhood, a sense of coherence among the people, and this is extremely important, as you can imagine, in the support of a community-originated and -oriented activity such as a health center.

The North End Health Center got started primarily because of people's dissatisfaction with the medical services available to them. Traditionally, the community had looked to the MGH and to a lesser extent, to the Boston City Hospital for their health services. At that time the MGH was a back-up hospital for the numerous practitioners of medicine in the West End. Two things happened. First of all, as has happened throughout the country, the general practitioners, the private practitioners in the West End, were not replaced adequately as they retired or died, and so there was a decrease in the immediate availability of services at the community level. Second, in my opinion, the great days of the National Institutes of Health and its influence on teaching hospitals and medical schools diverted the attention of the MGH from its communities, including the North End. I think people there sensitively felt that the hospital might have lost interest in them to some extent, and they did not like this.

About five years ago, they began to ask themselves what could be done. They knew about neighborhood health centers — there were others in the city; they knew that federal funds were available to assist, and so a group got together and began to organize what now is the North End Neighborhood Health Center. The had the assistance of the Tri-State Regional Medical Program at the time, in terms of money to get started on their studies; they had really expert assistance from competent people in health services administration and planning, and were able to move forward quite rapidly. It was decided that this would be an independent center. Some health centers, you know, are owned and operated by other agencies. For example, the MGH operates the Bunker Hill Health Center in Charlestown, and the city Department of Health and Hospitals runs numerous health centers; but the North End people, with their fierce independence, wanted to have their own board. The organization is set up as an independent voluntary health agency with a board comprised primarily of community people — no institutional representatives on it at all — and this board sets the aims for the center, defines for us who work there the job we ought to do, and lets us know what the community wants us to do.

In the four years of its actual existence, the heatlh center has made much progress. We have a wide variety of services: internal medicine, pediatrics, podiatry — an important part of our services; dentistry; mental health — there is a station of the Massachusetts Department of Mental Health located in the center; family planning; obstetrics and gynecology; ophthalmology; dermatology; allergy. These are all, of course, provided an a part-time basis, but present a wide spectrum of specialty services. The recruitment of physicians, nurses, and other personnel has not been difficult. We have been quite able to attract, on a part-time basis, a group of predominantly young physicians who 1) want an opportunity for direct and continuing responsibility for patients, and 2) happily, are encouraged by the hospitals and academic institutions with which they are associated, to undertake this kind of work. We are affiliated with the MGH, which has been increasingly eager to assist once more as a back-up hospital, and at the same time there has been an increasing realization on the part of the North End community that the health center had to have a back-up hospital, and that the MGH was the proper one. Indeed we really could not operate without the MGH and the Massachusetts Eye and Ear Infirmary providing the kind of services that are simply too specialized for us to undertake.

It is still an evolving situation. We now have about one hundred patient visits a day, which really is pretty busy; we refer a lot of patients to the MGH; we struggle with the question of expanding our services; we struggle with the problem of increasing size. When the number of patients was thirty a day, it was possible to run the kind of intimate family health center the people wanted; now with a hundred a day and the prospect of that increasing for the multitude of services, the complications of running any kind of big organization are beginning to raise their heads. One is increasing cost — it has been possible to keep the cost down to about ten dollars a patient visit, which is a significant accomplishment. But this has been done at the expense of the people who are underpaid and work long hours, and a reliance upon other volunteer services. As our operation gets bigger and more complicated, we no longer will be able to keep the cost down.

It is, then, an evolving situation — one that I am very happy indeed to be associated with. I had the opportunity to speak at this assembly five years ago, and the thrust of my remarks then was a plea that medical schools and teaching hospitals identify the communities they serve. It seems to me that is an absolutely essential thing for the vitality and meaningfulness of such institutions. My work at present in the North End is an extension of that same concern.

From Bethesda to Brooklyn via the White House

by Leonard Laster '50

I have made my way to this point in time and space in the finest tradition of the Mission Impossible stories. One bleak Monday at the Downstate Medical Center, the telephone rang during a meeting of the ad hoc committee to consider alternative courses of action should Mayor Beame sell New York City (and our primary teaching hospital along with it) to the Shah of Iran. It was director Culver calling from Central Headquarters. My assignment, if I chose to accept it, was to deliver an autobiographical talk on Alumni Day. I was to be amusing, he said, but brief. I was to be profound, he said, but brief. "Let us know what you've been up to these twenty-five years, Len," he said, "but be brief." I accepted the assignment fully expecting that director Culver, the telephone, the ad hoc committee, or I would immediately self-destruct. Instead, after what seemed to be only a momentary interval, there came a second telephone call. "Now that you have thought it through," they said, "we'd like a title for your talk." The title came easily: "From Bethesda to Brooklyn via the White House." However, even now I find the true meaning of the title far off in the distance, elusively jogging up and down the bucolic highways and byways of my mind. Perhaps it will appear on the horizon before we part.

The past few years have left me feeling somewhat like a character in an allegorical novel, albeit a novel still in search of an author, and I should like to share some impressions with you. Let me take the kernel of my story, to be unfolded for you in a moment — a kernel without character or form — let me place it in a bowl of water, as did Proust in the overture to *Swann's Way,* and let us watch this dry, shapeless mass become wet, twist itself, grow, take on color and distinctive shape, and become perhaps a blossom, a person or a concept. The kernel began as three happy years at the MGH and continued at the NIH. The intention, at first, was to stay at the NIH for two years. The eventuality grew into sixteen. At NIH, during the days one worked in the laboratory, cared for patients, and taught at nearby medical schools. During the evenings, especially in the early, salad days, one marveled at the unbelievable good fortune actually to be paid to enjoy oneself so thoroughly. Such was the spirit then.

In 1969, after brief, but intensive, interagency negotiation, I was lent by the NIH to the Office of Science and Technology to work with the President's science adviser, Dr. Lee duBridge. During the days at the OST, one tried to help shape national policies related to health care, health services research, biomedical research, and allied areas. During the evenings, one repressed anger, nurtured outrage, and grew deeply concerned over what appeared to be the subsidence, if not the renunciation, of the renaissance in American biomedical research. The intention, at first, was to stay at the OST for one year and then return to the NIH. The eventuality was a three-year stay that ended when the lights were extinguished in 1973 after the office had been abolished by presidential decree. I did not return to the NIH because by then, it seemed to be a very different place. Instead, I moved to the NRC (National Research Council), another three-letter institution. The intention, at first, was to stay for many years to help forge national programs in the biomedical sciences. The eventuality was far different because within the first year I undertook a stock-taking of the sort Dr. Bohrer urged upon us all during his talk. I decided one morning to step out of the corridors of power, to leave the profound but sometimes soporific debates around antique oaken tables, to forego the view from Olympus, and to journey to the real world.

In 1974, I moved to the Downstate Medical Center of the State University of New York. In contrast to Dr. Brennan, I was not a native returning to Brooklyn, but a stranger coming to be a native. I suppose that the previous years of sitting at meetings during which muscles hypertrophied from exercises of futility had left me fit only for service as a dean and vice president, and it is in such roles that I find myself at the Downstate Medical Center. This, then, is the kernel of the story.What emerges when it is immersed in water? Let us try it as vignettes and phrases; not sad, not discouraged, but rather tinged with optimistic realism.

First, the Bethesda days, the NIH days. I recall my astonishment, the first time I ever drove onto the grounds of the NIH, that the federal government would and could create a university-like campus and a research hospital in so handsome a setting. I recall the sense of pride in being part of that island of excellence. In time, the local names became internationally renowned — Nirenberg, Anfinsin, and Axelrod. A sense we all seemed to share was that summer would last forever, that the very quality of the effort — both intramural and extramural — lent it perpetual strength and invulnerability.

As the years went by, the young scientists that passed through the NIH spangled this country with talent — in medical schools, in hospitals, and in research institutions. It was interesting to observe, too, the effects of the NIH on the local community. The quality of medical care in the immediate area did not seem terribly impressive when I arrived. However, as alumni of the Institutes settled there and took up the practice of medicine, and as the initial mild hostility between the surrounding medical community and these newcomers lessened, there was a palpable and impressive improvement in the quality of the local medical care.

Within the NIH there was a felicitous exchange between the clinical and the basic sciences. There were luncheon table discussions between clinicians with unusual patients and basic scientists who had first worked out critical biochemical pathways, and not infrequently the two would join together to elucidate the fundamental defect in an inborn error of metabolism. There were interesting sociological facets of life at the NIH such as the problem of living in an environment in which internal rewards depended exclusively on research accomplishments. In a medical school, when one's research doesn't go well, one can derive gratification from teaching, from guiding students, or from managing a patient's problem particularly well. In contrast, the atmosphere at the NIH was very intensely related to research. Some individuals left, perhaps because of this, and were happier elsewhere. Some left and returned.

Dr. Laster

One recalls a profusion of dedicated and talented public servants in the NIH leadership: James Shannon, John Sherman, Robert Berliner, and many others. In the tradition of being obligated to tell stories in a talk of this type, I will now relate one that is totally irrelevant. It's a Shannon story. We had in front of the NIH Clinical Center a plot of grass much the size of the one upon which you sit. One day, twenty workmen appeared and cut the sod into many small squares. They rolled them up and carted them away. One week later they brought the squares back and put them in place. The following week the men returned and took the squares away again. After the cycle was repeated three or four times, I personally conducted a survey designed to elicit the best conjecture to explain this strange behavioral phenomenon. The most interesting response was that because Shannon hated the sound of lawnmowers, when the grass needed cutting he had it rolled up, carted away, cut and returned.

As I look back, I find that many of us were naive to a fault. We assumed that the fundamental value to this country of biomedical research and research training was a self-evident truth, even to those whose daily lives were far removed from medicine. The first clouds darkened the horizon in 1968, when the President came to talk at the NIH. He indicated that we in research had, to some extent, failed the country; that information in our laboratory notebooks was not reaching the bedside; and that we were, thereby, denying sick patients the fruits of the nation's investment in the NIH. This attribution to the research community of failures in the process of delivering medical care grew during the subsequent presidential administration into a conceptual polarization of research against care.

I recall a surprising dinner conversation just after the President's talk at the NIH, with a Washington attorney, a Yale graduate (but well educated, nonetheless) who might reasonably have been expected to understand the contributions of biomedical research to national welfare. I prophesied that several years hence American biomedical research would be seriously impaired and I expressed a wish that the entire country could be made aware of this possible outcome. I voiced the opinion that people would rise up and demand that the research enterprise be protected and preserved. My dinner companion's reply, unexpected in content and hostility was, "The hell we would. It's about time you guys got it. You've been living like fatted calves for twenty years. You go to plush meetings every other week. You don't give a hoot about sick people," and on and on in that vein. This was a personal friend, and it was shocking to see ourselves as others — some others — saw us. There were additional comments about our intellectual arrogance and our insensitivity. Those, then, were the Bethesda days.

Next came the White House days. These I would characterize as the end of innocence. The day I walked into the OST the federal budget for research training grants was cut by twenty million dollars. Frantic calls came in from friends who said it was "up to you, Len, to do something." I walked those corridors of power and ultimately reached the White House staff man for domestic policy. He allowed me an hour, and I discussed, not as eloquently as Lewis Thomas, but with equal sincerity, the future of biomedical research in this country. The staff man's response was an order banning the "zealot" from his office thereafter. The budget cuts remained intact and it was downhill from then on.

Congressional attitudes, too, were changing. Research began to be regarded not as the synergist but as the antagonist to health care. The Bureau of the Budget insisted on requiring cost accounting of such intangibles as medical education. How do you cost out the value of quality in medical education? If you couldn't, you were lost in that era, because failure to balance the accounting sheet meant cuts in budgets. I specifically remember one staff member in the Bureau of the Budget saying, "You expect every doctor in this country to be a Harvard graduate. We don't need that many. Most patients just need some aspirin, and we can provide that with doctors who don't know that much." Ironically, when that same person became ill he called and asked if I knew a good doctor.

The budgeteers were very comfortable with hardware. If you talked about sending x-ray pictures by satellites, they would listen. If you talked about kidney machines or helicopters for emergency medical care, they could understand that. But when you discussed developing insights into the workings of the body's immune mechanisms and their ultimate relevance to health care, you were speaking to yourself because they couldn't see, taste, feel, or cost account the immune mechanisms.

Then came the cancer adventure. At first the support for a Los Alamos-like effort and a separate cancer agency came only from the Congress. Because it was a program of the political opposition, for a brief time we in the White House were permitted to oppose it. So we undertook a vigorous effort to stimulate a national debate on the pros and cons of a separate cancer agency. Had the time really come, we asked, for a managed and strictly directed research program in cancer, or were we still, regrettably, at the stage when we had to look primarily to investigator-initiated programs for new leads? Then, quite suddenly, White House signals veered off course by 180° — the President, too, now endorsed a strictly planned and controlled cancer research effort and moved to outbid the Congress in this thrust. The cancer adventure still continues and who, if anyone, was right or wrong remains to be determined. Obviously there are strong arguments on both sides, but the time of reckoning is almost upon us. Perhaps one current legacy of the controversy over who is best qualified to direct biomedical research is a recent bill enacted by the House of Representatives requiring each research grant approved by the National Science Foundation to be reviewed by the entire Congress before funding. That is the extent to which political intrusion on scientific judgment may come. The bill has not yet been passed by the Senate. Several weeks ago a prominent scientific statesman said in discussing the House bill: "It is a ridiculous bill but you can't laugh at 250 Congressmen." I guess he was right, but as I recall Will Rogers made a living laughing at all of them for many years.

There were frequent and erratic shifts in national science policy. Training grants were in one day and out another. Such behavior, obviously, was highly destructive to orderly enterprise. There were catch-22's. If one was technically expert in one's research field, by definition one had a vested interest and was self-serving, so one's advice on the future of that field was suspect. There were interminable debates over short term and long term goals, and, as in any political administration, the short term goals generally, if not invariably, prevailed.

Quality. Quality of medical teaching. Quality of health care. Quality of the mechanisms for providing that care. All these were outside the budgetary equation because quality was too difficult to cost account. The result of the White House days was the absence of a truly comprehensive national policy orchestrating the relationships between research, improvement of health care, and medical education. If past is prologue, when such a policy finally emerges it will probably be the integral of fragmented, internally inconsistent — and possibly self-defeating — segments of logic. It will probably reflect inadvertent and benign neglect, as well as such willful destructiveness as the politicization of the NIH directorship. It is saddening to predict that this policy will not be the result of a clearly defined national debate and an informed public decision.

We should, note, too, that many of the behavioral patterns encountered during the White House days — arbitrariness, arrogance, abuse of power, and even intellectual dishonesty — were not, and are not, confined to Washington. They appear within our own local arenas, and are perhaps general attributes of an era, an Age of Shoddiness and Mediocrity, but that is a subject for another talk.

I shall touch only briefly on the Brooklyn days. In Brooklyn we live with every problem imaginable related to the care of the sick and the prevention of disease:

- We must elevate the overall quality of medical care for everyone;
- we must redesign antiquated and inefficient systems for providing medical care;
- we must eliminate costly duplications and regionalize medical resources;
- we must encourage young doctors to settle in Brooklyn to replace the older ones who are dying off and whose numbers are dwindling; and
- we must teach young people to become doctors in the eighth largest medical school in the country with faculty and resources appropriate for a school one-half that size and still preserve the humane values of medicine.

To those of us who teach and work in Brooklyn, these problems are challenges — challenges that make it exciting and invigorating to go to Downstate each morning. It is a meaningful contrast to life in Washington because it is possible to see words and ideas translated into tangible accomplishments. One can see doctors cure patients. One can see teachers create a new course in the medical school. One can see the

devotion of a new physician in helping to improve the quality of care in the emergency room of the county hospital.

Some of our problems and challenges derive from living at the confluence of all that is counterproductive in three levels of government: city, state, and federal. Nevertheless, our medical school is nurturing a sense of rededication, a sense of excellence, a sense of change, a sense of individual worth, and a sense of excitement at being part of a renewal of spirit.

So let the Congress create ill-conceived approaches to the problems of maldistribution of medical manpower. They would force us to increase the number of students in our overcrowded school and they would force them to practice in "medically underserved areas." But when one studies federal lists of underserved areas, Brooklyn is nowhere on these lists. Brooklyn with its aged, dying generations of doctors, Brooklyn with 2.7 million people and no cancer center, Brooklyn with all its medical problems, is not a federally-acknowledged "medically underserved area!" We need resources to remodel and create new systems of health and not pressure to increase enrollment. When it becomes possible to deliver high quality care and to treat patients with dignity and kindness, our current number of graduate physicians will suffice to repopulate our borough and other "medically underserved areas."

So let the federal government ignore the proud achievements of the NIH, and permit it to wither by inadvertent neglect. Let the State of New York pursue bargains in cut-and-paste medical schools, by hoping to take a two-year college here and a voluntary hospital there, put them together and call them a medical school, with no apparent concern for the quality of medical education. So let the city neglect its municipal hospitals and reduce the quality of care they deliver.

Let all this darkness loom and still we shall fight on. We few, we happy few, we band of brothers and sisters shall prevail, still caring for the sick and infirm, growing older, always learning. And the light from our candles will illuminate the paths of others out of despair, disillusionment, and hopelessness. Let tomorrow come. It can, it shall, it must, bring more wonder, more challenge, and more accomplishment.

This, I believe, is what I found in my journey from Bethesda to Brooklyn, via the White House.

Reunion Reports

1925

Twenty-two classmates, thirteen wives, and five guests gathered for this our last major roundup. Seven other classmates had indicated every intention of attending but were prevented by last minute complications.

Almost everyone in our group attended the Alumni Day program and luncheon in the Quadrangle — as well as the most enjoyable cocktail party and dinner that evening at the Harvard Club. We were very pleased that Dean and Mrs. Ebert honored us with their presence.

As at our forty-fifth reunion, Jim and Jo Baty were our host and hostess for an old-fashioned clambake at their lovely Duxbury home on Saturday afternoon. Before returning to Boston, many visited the spectacular azaleas and rhododendron gardens of the Richard Patricks.

Dorothy Murphy was our special guest at the Batys' and told us that, from her experience in the Alumni Association, attempts to organize reunions beyond the fiftieth had never been successful — therefore this is it.

To paraphrase the words of Daniel Webster (as he addressed the veterans on laying the cornerstone of the Bunker Hill Monument), "Heaven has bounteously lengthened our lives that we might behold this joyous day." It does give us great joy to greet again our colleagues of fifty years, to give our deep gratitude to the Medical School that trained us for our life's work, and to pause and pay silent tribute to the sixty-nine classmates who have preceded us.

Stewart H. Clifford

1930

If one thinks of a forty-fifth reunion as a meeting of septuagenarians, it seems a bit ominous — like Carl Walter's recent letter suggesting that one remember HMS in one's will — but there was nothing ominous or disheartening about 1930's affair. At least fifty-one members of the class appeared at one or more of the programs and there was a notable absence of any doddering. Furthermore, several who did not appear were much too busy to do so! Things really look bright for the fiftieth.

A special tribute is due the many 1930 wives who attended Alumni Day, the dinner, and the clambake. They were loving, lovely, lively, and the leaven of the loaf — God bless 'em.

The scientific section, enhanced by sometimes scintillating moderators, provided solid brownie points for potential Physicians' Recognition Award aspirants. Alumni Day presentations provided entertaining and ample evidence that HMS still is vital, exciting, provocative, controversial — and involved! Several classmates got involved and failed to appear for the class photograph — too bad!

The open bar and a good dinner Friday night in the Massachusetts Room at the Harvard Club were highly enjoyable. Miss Dorothy Murphy, "General Factotum of the Dean's Office and the Alumni Office for more years than we have been physicians," graced the head table and obviously had not faded away. Arthur Hertig appropriately recognized the plaudits of his classmates for compiling and editing in his inimitable way the forty-fifth reunion report. He had a good excuse for not attending the clambake — departure for London to be inducted as a Fellow of the Royal College of Obstetricians and Gynecologists. Langdon Parsons, gynecologist, teacher, and former director of alumni relations regaled the party with pertinent sketches that enhanced his well-known reputation as a most genial guest.

Despite confused arrangements and threatening (but finally benign) weather, the clambake at enchanting Castle Hill in Ipswich fittingly culminated the reunion — the bar was open, the lobster just right, and the service unobtrusive. Amateur photographers had a field day, reminiscences were heartwarming, tales of the trail were modest. 1930 had a good time, although absentees were sorely missed.

David Wallwork

1935

Many classmates and wives turned up for the Alumni Day speeches in the Quadrangle on Friday morning, and the luncheon provided was very much enjoyed by all. At 2:30 p.m. we boarded a bus which took us to Woods Hole. Here we met more classmates who had driven down by car, and incidentally missed all the fun on the bus. The ferry trip to Vineyard Haven was particularly exciting for those who came from the Midwest. The Harborside bus met us and the eight mile trip to Edgartown was painless.

I think it is fair to say that all of us were very much pleased with our stay at the Inn. The accommodations, food, and service were all good. The weather did not cooperate, and we had much fog. A trip about the Island was organized by John Norcross, and we were thoroughly entertained by the driver, who was a native and a remarkable raconteur. The Island is full of interesting places, some old, some new. At Gay Head the visibility was exactly fifty feet, just short of the breakers which we could hear below. That evening we enjoyed a superlative shore dinner, a clambake served indoors because of the inclement weather. And thereafter we sang to the piano accompaniment of Dave Clement and George Filmer — reminiscent of Medical School days.

Sunday morning was spent by the wives rummaging about the many interesting shops and historical spots in Edgartown; and that noon we left for home.

In Medical School we developed some feeling of group unity — certainly much more so than any group of college classmates. After forty years, this group feeling has been accentuated, and it was a pleasure for me to find everyone enjoying each other so much. In fact, we spent all of our time together and there were no splinter groups. The sentiment was expressed that meetings of this nature should be more frequent than every five years. We'll have to see about that.

There were twenty-two classmates on hand, all with wives except for two. The travel prize was won by Pete Olcott, who came from Haringen, Texas; and Bill Cover and wife, who traveled all the way from San Bernardino, California.

Classmates present included: Samuel D. Clark, David H. Clement, William L. Cover, Edward C. Curnen, Jr., Gordon A. Donaldson, George A. Filmer, Wilber E. Flannery, Travis A. French, Thor Gunderson, John W. Henderson, Joseph A. Holmes, Isaac H. Manning, Jr., Carroll C. Miller, Halcuit S. Moore, Jr., John R. Mote, Cornelius Olcott, Jr., Philip F. Partington, Gordon Saunders, and William Weir.

Gordon A. Donaldson
Lamar Soutter

1940

HMS 1940 does it again!! We had a great reunion, with renewal of new and old friendships, discussions of medicine and society in general, sociability, sightseeing, and entertainment.

Following a great planning evening at Tom and Dottie Paull's we had the return of some sixty plus members and wives to Alumni Day, welcome hour at the Colonnade hosted by President Arch Deming and Anne, nearly two misty-rainy days at Chatham Bars Inn with entertainment by and arranged by Sam Potsubay. Never play cards even with a friend! Fishing trips arranged by Bill Hickey, our treasurer, and an Audubon tour by Gordon Scannell were both rained out. Ringleader Bob Arnot was at his best.

Some of the furthest travelers were Jim Thompson and Hattie from San Francisco, Ed Grafton and Christine from Dallas — where else — Texas, and Riv and Edith Randolph from Georgia, suh!

The class summary information was well organized and completed by Tom Gephart (who was at his son's graduation from Princeton) and Gordon Scannell. It contained most interesting observations on life and medicine.

Thanks to much help from everyone, it was a great reunion.

Rodney C. Larcom

1945

A total of forty-two members of the class attended one or more of the alumni weekend events. The high point was surely the kickoff buffet held at the charming Beacon Hill home of our leader, Ike Taylor. Wives and sundry ladies joined in an informal evening of chatter, painful assessment of hair color, hair amount, umbilical measurement and a lovely rooftop view of Boston on a delightfully warm spring evening. The luncheon on Alumni Day saw some thinning of the ranks but the transient appearance of a few new faces who spoke of some boredom with the rat race, a search for new relevance in a changing medical scene, and even a look towards that ever less distant day of possible retirement.


1945

The numbers of classmates dwindled to a bit less than twenty for the weekend adjournment to the seaside resort of Harborside at Edgartown on Martha's Vineyard. Despite some marginal weather conditions, the presence of the ladies and the camaraderie of the class of '35 permitted some sheik house-partying reminiscent of Vanderbilt orgies of yore. Tennis, sight-seeing around the Island, excursions to Chappaquiddick, and fishing finally culminated in a smashing New England shore dinner on Saturday night.

Jackson, Landing, and Vaughan shared the prize for greatest distance traveled (California). José Sarraga won honors for most charming accent. Boles and Schenk have aged the least. On to the thirty-fifth!

Joseph M. Miller

1950

Our reunion started with a delightful cocktail party and dinner aboard the S.S. Stuyvesant at Pier 4, well attended by local as well as distant members. We were honored by the presence of Dean Ebert and half a dozen members of the Alumni Council, and enjoyed the after-dinner talks of the Dean, Bert Dunphy '33, and Frank Williams '64, who ended the gathering by leading us in singing "Gaudeamus Igitur."

The Alumni Day program included contributions from three of us: Ralston R. Hannas, Jr., Leonard Laster, and me.

Friday afternoon, fifty-three classmates and spouses took a chartered boat from Hyannis to the White Elephant in Nantucket. The rain kindly fell mainly at night, so that the warm, gray weekend


1950

permitted outdoor activity. A cocktail party and dinner on Saturday were followed by Sheldon Levin's movies of our class day in 1950. We really enjoyed the shots of a great many of us, still recognizable. Willis Schaupp also contributed some marvelous photographs of the 1950 senior play, which were hung on a bulletin board.

There was a lovely feeling of warmth and happiness at being together, renewal of old friendships, and deepened relationships in general. The twenty-five years of personal and professional living seem to have brought us to closer understanding, and we departed in enthusiastic anticipation of future reunions.

Evelyn Davis Waitzkin

1955

After an exceedingly interesting scientific program on Thursday and Alumni Day on Friday morning, the reuning members of the Class of '55 gathered for a superb banquet at Anthony's Pier 4 on Friday night. The elegant feast was arranged by Ron Malt, the official class gourmet (unchallenged by Kenny Warren, who didn't show).

The next afternoon, we "reconvened" — many with children — for a steak and lobster bake at the beautiful Weston home of Patty and Jerry Austen. We were all grateful that at least one of our classmates in the Boston area had been successful enough to have a home big enough to accommodate us! Seriously, Patty and Jerry were superb hosts and the class expresses special thanks to them.

All in all, about forty class members participated in the various reunion activities. Several came long distances — George and Marilyn Cobb, Ellis and Ginny Rolett, and Paul "Peppy" Steinman — all from California; Eric and Carol Gunderson from Wisconsin; Pete and Evelyn H'Doubler from Missouri; Jim and Doris Greene from Michigan; and Jim Pierce from Virginia. Paul Steinman came with an armful of nostalgia in the form of pictures of many classmates taken in Medical School.

I am sure I speak for all who came when I say that we had one hell of a good time.

Special thanks also go to the other members of the reunion committee, who, in addition to Ron and Jerry, included Chuck Keevil, Ernie Picard, Mitch Rabkin, and Eleanor Shore.

To those classmates who did come, and to those who did not, you've got to make the twenty-fifth — if for no other reason than to hear Mitch Rabkin's latest jokes!

Roman DeSanctis

1960

The Class of 1960 celebrated its fifteenth reunion with enthusiasm albeit with sparse participation. Several alumni renewed acquaintances at the Scientific Symposium but we gathered Thursday night at the Aquarium for a banquet. It was a joy to walk about the fish tanks, glass in hand, and see strange creatures from long distances — why, one came from California! (Rex Jamison)

We had the pleasure of Eric Ericson's company for the weekend, for we had invited him and his wife to join us. He hasn't aged — and still has a blue shirt.

Several alumni sent letters of regret but the most convincing was from Bob Schaller — he's in Tibet climbing Mt. K-2.

On Alumni Day an intrepid few showed up for the official class picture and stood in long lines for a glass of beer. That afternoon we drove to The Chatham Bars Inn for the remainder of the weekend. The Inn supplied our

every need but one — they substituted fog for sun. No one got a tan, but we can confirm that what Bill Gallagher wrote in the class book is true: practically our entire class is into tennis. The male tennis round robin was won by Marshall Kaplan and Erv Philipps and the female event by Mary Kimball and Meade Fasciano. The classmate who came the furthest was Eric Jensen who airport-hopped for two days before he finally arrived from Seattle.

The Inn has many individual cottages on its premises, one of which has a huge living room. This room served as our headquarters and permanent bar. Here we were by ourselves and all present were able easily to mingle and mix with the others who had made the effort to come. All agreed it was a marvelous weekend — those who didn't go missed out, but perhaps we'll see them at the twentieth.

Richard A. Kingsbury

1965

As we reconvened on the Quadrangle for Alumni Day, it was quite apparent and comforting that in ten years, except for minor alterations in hair color and hairline, no one has changed very much. Classmates came from considerable distances: Bill and Ann Barry and their children, from Palo Alto; Bob and Roman Beck, from San Antonio; Jim Nelson, from Salt Lake City; and Dick and Ursula Neeley, from Colorado. Chuck McRae flew in for the day, and returned in the evening to make rounds in Reading, Pennsylvania.

The evening began with cocktails while Jeff Stein, Bill Couser, Glenn Haughie, Dick Seder, Henry Schniewind, Pete Reider, Tom Smith, Charlie Langston, and Paul Cox reminisced back to undergraduate days as we cruised along the Charles aboard the M/B Holiday, unbothered by slight rainshowers. John and Judy Carmody, Dick and Sharon Aadalen, John and Florence McNamara, Mike Stewart, and Bob Bernstein enjoyed Friday's activities which wound up with dinner in the penthouse at Holyoke Center.

Saturday, the weather cooperated and it was family day for thirty classmates who gathered at our summer home on Plum Island for a clambake. Jack Babson's Daniel had a birthday party attended by forty other children of our prolific class. Zero Population Growth has not reached Horst Filtzer, Bob Trelstad, Walter Reiling, and myself who have four children each. Kenny Ratzan's four-month-old was the youngest guest. Bill Clark organized a vigorous game of volleyball and then braved the cold water at the mouth of the Merrimack River, accompanied by Jim Wallace, Clyde Crumpacker and Cecil Chally. Dave McKay got a chance for beach-combing along with Nelson Burstein, Gretchen Lange Collins, Sandy Uberlander, and Gerry Clermont. Terry Langer and Gary Poser lingered for dancing.

We had a wonderful weekend and were happy to share it with Morris Fisher '68 and Roger Christian '66. See you in 1980.

Lesley Bunim Heafitz

1970

The Class of 1970 had a well-attended and highly enjoyable fifth reunion, with over seventy people present.

Friday evening, the cocktail party in Vanderbilt Hall was highlighted by the attendance of two favorites of our class, Dr. Hermann Lisco and the Honorable Tom Wright. A surprise showing of Tony Brever's two masterpiece class movies topped off the evening. A large segment of semi-anesthetized party-goers staggered off to the Peking-on-Fresh-Pond Restaurant for a late evening feast.

On Saturday, the shaky weather held up, and the clambake/outing at Perry Culver's beautiful home was a great success. Classmates, spouses, children, and dogs all had a great time. The usual softball game was hotly contested, and though the batting eyes were a little rusty, the defensive play was surprisingly good.

As we sadly dispersed to go our separate ways, we all agreed on two matters: our high praise for Steve Raskin's labor of love, our five year class report; and our resolve to have another big turnout of "The Happy Class" in 1980.

Michael B. Millis

Class Day 1975

The degree of Doctor of Medicine was conferred upon 130 men and 32 women at the 1975 Class Day exercises held on the quadrangle on May 31. Alvin F. Poussaint, M.D., associate dean of students, announced the following awards and prizes for members of the Class of 1975:

The Richard C. Cabot Prize for a paper on "medical education or medical history, preferably of persons or incidents of the twentieth century," to Jon R. Polansky for his paper, "The Iodine-containing 'Active Principle' of the Thyroid Gland."

The Henry Asbury Christian Award "to the student in the fourth year class who has displayed diligence and notable scholarship in his or her studies or research and offers promise for the future," and the M.D. degree *magna cum laude* in a special field, to Fred M. Feinsod for his thesis, "Neutralization of Sindbis Virus by Antisera to Antigens of Vector Mosquitoes."

The Leon Resnick Memorial Prize "to the fourth year student who has shown excellence and accomplishment in research conducted during his or her period of study at the Harvard Medical School," and the M.D. degree *summa cum laude* in a special field, to Victoria Chan-Palay, Ph.D., for her thesis, "Organization in the Cerebellar Dentate Nucleus of the Primate: On Cytology, Experimental Pathology, and the Identification of Neurotransmitters. Volumes I and II." The degree *summa cum laude* has been awarded only four times before in the history of Harvard Medical School, and Dr. Chan-Palay is the first woman to win this distinction.

The Rose Seegal Prize for a paper on the "relation of the medical profession to the community" to José Gabriel Rigau for his paper, "A Student's Practice of Medicine in Castañer, Puerto Rico."

The James Tolbert Shipley Prize "for research carried out by a medical student, the results of which have been published or accepted for publication," to Robert H. Brown for his paper, "Membrane Surface Charge: Discrete and Uniform Modeling," published in *Progress in Biophysics and Molecular Biology,* 28, 1974.

The M.D. degree was also awarded with honors to the following graduates:

magna cum laude in a special field:

Stephen L. Hauser, for his thesis, "Pneumographic Findings in the Infantile Autism Syndrome: A Correlation with Temporal Lobe Disease."

cum laude in a special field:

Tobin N. Gerhart, for his thesis, "Cryopreserved Lymphocytes in Mixed Lymphocyte Culture and Variability of the Mixed Lymphocyte Response."

Edward M. Kwasnik, for his thesis, "Circulating Agents Associated with Pneumonitis in Non-Thoracic Sepsis."

Richard J. Morgan, for his thesis, "The Effects of Ventricular Fibrillation, Hypothermia, and Hypothermia Plus Potassium Induced Cardioplagia on Ventricular Function Following Aortic Cross-Clamping."

Kenneth O. Rothaus, for his thesis, "The Role of Alpha Adrenergic Receptors in the Onset of Digoxin-Induced Tachyarrhythmias."

Daniel G. Tenen, for his thesis, "Structural Variability Among Murine Type C Viral P30 Proteins."

Frank H. Valone, for his thesis, "*In vitro* Studies of the Migration of Human Platelets."

Alan M. Weinstein, for his thesis, "Thermodynamic Relations in a System of Parallel Flow Tubes."

Twenty-seven members of the Class of 1975 were elected to membership in Alpha Omega Alpha, the national medical honor society.

Members of the graduating class also received *The Care of the Patient* by Dr. Francis Peabody, given under the auspices of the alumni association. Through the generosity of Frank J. Lepreau '38 and Perry C. Culver '41, reprints of this book will be presented to "future graduates of Harvard Medical School to perpetuate the medical philosophy of Dr. Peabody, a caring

physician." This inscription appears on the bookplate, which was the gift of Mrs. George Shattuck, wife of the late George Cheever Shattuck '05.

* * *

The degree of Doctor of Dental Medicine was conferred upon fourteen men and two women. Honors and awards for graduates from the Harvard School of Dental Medicine were announced by the dean, Paul Goldhaber:

The Harvard Dental Alumni Gold Medal award for "all-round scholastic excellence," and the D.M.D. degree *cum laude,* to Steven P. Irving.

The Harvard Dental Alumni Silver Medal award, and the D.M.D. degree *cum laude,* to Robert C. Fazio. Dr. Fazio also received the Grace Milliken Award for "the outstanding paper in the field of dental health" for his paper, "A Study of the 'Broken Appointment' Patients at the Children's Hospital Medical Center Dental Facility, Boston, Massachusetts."

The Harvard Odontological Society Award to Jack E. Gotcher, Jr., who also received the D.M.D. degree *magna cum laude* in a special field, for his "Dose Response Study of the Disodium Dichloromethylene Diphosphate (CL_2MDP) on the Bone of the Growing Rat."

The Norman B. Nesbett award for "excellence in the field of dentistry," and the D.M.D. degree *cum laude,* to Rocco R. Addante.

The D.M.D. degree *cum laude,* to Barry M. Shapiro.

Three members of the graduating Dental School class were elected to membership in the national dental honor society, Omicron Kappa Upsilon.

* * *

A highlight of this year's Class Day was the unusual musical interlude. Instead of hearing the traditional Harvard Band performance, the audience was treated to Mozart's "Quintet in A Major for Clarinet and Strings, K. 581." The musicians were Daniel Lee '76, violin; Kathryn Zufall '76, violin; Yeou-Cheng Ma '77, cello; Peter Thurlow '77, cello; and Norman Letvin '75, bass.

Valediction

by Robert H. Ebert

Each year it is my privilege to extend to the graduating class my congratulations and to make a few remarks about the state of the world of medicine now and in the future. It is always tempting to say that this is a critical time, or a time of crisis or a time for decision, as though the present were unique. This is usually safe to say because there is always ample evidence that problems abound. What is not said is that many of the problems have been around for a long time and that it is unlikely that any revolutionary solutions will be implemented. That is not the style of our form of government. Nor is it our style to solve problems directly by legislative means. We tend to approach solutions piecemeal and with a good deal of lateral motion rather than head on, and there is no evidence to suggest any substantial change in that approach. Nevertheless, during your lifetime of practice some profound changes will occur — but they will be gradual.

I am often asked if I believe that this country will have a national health service — or, in the more customary jargon, if we will have socialized medicine. My reply is that I very much doubt that medicine will be nationalized because, once again, that is not our national style. Even if all health care were federally funded, it is far more likely that government would purchase services than that it would provide them directly. But the more the government pays, the more tightly will it regulate the delivery of health services. Indeed, the major changes that come about during the next several decades will be via the mechanism of government regulations at all levels. Let me outline briefly where I think regulation will occur and how it may affect you in the practice of medicine.

• The cost of health care is escalating at a rate that cannot continue indefinitely without consuming a major

Dr. Ebert

part of the gross national product. Ultimately, cost will be controlled by government regulation. It is not possible to predict precisely how this will be done, but there are some rather obvious starting places. A major part of the cost of medical care is hospital care — and the greater the number of hospital beds, the higher the costs. I predict that there will be much more stringent control of the number of hospital beds in the future — indeed, this has begun. The duplication of expensive services in neighboring institutions is another obvious place to control costs. This means that physicians will no longer be able to persuade hospitals to expand or to develop new services without justification with reference to the needs of a region. Similarly, as the fee-for-service system of payment encourages the provision of expensive services, this too is likely to be controlled, even though the fee-for-service system remains. In other words, the physician may not be paid for services which are judged to be expensive and of marginal value.

• There will clearly be control of the numbers allowed to enter the various specialties of medicine. The two major health manpower bills before the houses of Congress both deal with the numbers of residencies to be certified and the distribution of places among the specialties. The profession may be allowed to implement these controls through its various agencies, but it is unlikely that they will be allowed to change policy without the approval of the Department of Health, Education and Welfare. Such regulation will not only permit a more equitable distribution among the specialties, but will also control indirectly the influx of foreign medical graduates.

• The Professional Standards Review Organization legislation is a first step in the regulation of the practice of medicine by the individual physician, and that control will be extended. Physicians will have to demonstrate from time to time that they meet the norms of practice in their specialties, and control of payment and licensing will provide the authority for the regulation of practice.

• It is far less predictable how the geographic distribution of physicians will be controlled. The Rogers and Kennedy bills both attempt to approach this problem via the training of health manpower rather than directly through regulation of where physicians may practice. I am reminded of a story I heard from Dean Price of the Kennedy School of Government when we were discussing this problem. A mother brought her small child to school and told the teacher the boy was nervous but needed discipline. She suggested that if her child misbehaved, the teacher should spank the boy at the next desk — "That will frighten my son into behaving."

• There has been much talk about the rate at which medical research is translated into technology for practical care, and I am told that this is called "technology transfer." The conventional wisdom suggests that this transfer is too slow. My guess is that it may be too rapid, and that many expensive technologies are accepted into practice before having been adequately tested. I predict that such testing will be mandated in the future — if for no other reason than cost control.

• The research laboratory will not be immune from regulation, and it is already apparent that there will be much more formal control of all human experimentation.

One aspect of medicine, however, will remain unchanged, and it is the most rewarding part. You will still be helping individual patients, and I hope that each of you will do this in a humane and understanding manner. There are no specialty boards which assure that the physician will be kind or gentle or sympathetic — but these are qualities that your patients will appreciate as much as your professional skill.

Don't Practice on Me

by Judah M. Folkman '57

You have already heard so many words of wisdom; what could I say that would be of any value as you begin your journey in the hospital as new interns or house officers?

Let me tell you a story about a patient I saw when I was a new house officer. A little old lady was brought to the emergency ward with a broken hip. My duty was to assign patients to the appropriate admitting services. I remember asking my senior, "Which orthopedic resident should be called?"

At this the lady looked up with an expression as if to say, "I'm poor, but not destitute." She opened her purse, pointed to some ten dollars bills and said: "Could I have a real doctor . . . I think I can afford a real doctor . . . Don't let them practice on me."

I quickly tried to comfort her by explaining that although this was a teaching hospital, an attending staff surgeon would supervise the resident who operated upon her hip. Well, the hip was repaired, and she went home in good shape.

Many years later, at the completion of my training, I was, for some reason, reminded of her plea, "Don't practice on me." Her simple request now seemed to take on a more profound meaning. Perhaps without knowing it she had said something about what makes the medical profession unique.

The profession you now enter is perhaps the only human activity where every attempt to relieve suffering is accompanied by the risk that we may *cause* suffering. Sometimes the risk is small, sometimes great, but it is always there.

Now I am not talking about injections which hurt, or medicines that taste bitter. What I am talking about is what you and I know deep down, but what I think we have never dared to explain to the public — that good clinical judgment is learned from bad judgments. Good clinical judgment comes in the final analysis from the awful experience of making mistaken or bad clinical judgments. Oh yes, a little clinical judgment can be learned from one's teachers and some from reading the experiences of others. But by far, most good clinical judgment and clinical skill is learned the hard way, from practice.

The lady with the broken hip thought that only the intern "practiced" on people. She was wrong. We all do.

Dr. Folkman

By now you have seen, or soon will see, a child with abdominal pain and you think it is simple gastroenteritis, and you send the child home. But it turns out to be appendicitis and it is ruptured. The child nearly dies, but does not, and after that your clinical judgment is much improved. You tell your colleagues, "Gee, I really learned something from that case," but it was a frightening experience for the family. Or, you give penicillin, but forget to ask about allergy, with a disastrous result.

There is probably not a surgeon among us who has not had an anastomosis

leak, which nearly caused the patient's death, or did so. Would the patient have survived with a more experienced surgeon? Who is to say? But, the original surgeon, shattered by this experience, now becomes even more meticulous and develops the compulsive technique necessary for safe surgery, and subsequent patients do well.

Every surgeon knows of patients who would be alive today if they could have been operated upon at a time in the surgeon's career when he or she had had more experience.

I know of a general practitioner who, through years of practice, kept a catalog of all of his mistakes. As he progressed from house officer to *locum tenens,* to established practitioner, he became more savvy. He says, "Although I made many mistakes, I never made the same one twice, and therefore, I learned rapidly and gained a reputation as the best doctor in my region."

You and I travel the same learning curve. But even after we have mastered our particular fields, or reached the height of experience, we may still be the cause of our patient's suffering. This time, not from personal bafflement about the disease or, to use a better term, personal ignorance, but this time from general ignorance. I mean that patients may also suffer because our entire profession does not understand the disease, like cancer, or a disease even more insidious that we ourselves create without realizing it.

An example is the stilbesterol story whereby thousands of women were able to avoid repeated miscarriages and have normal babies, but we now discover, fifteen years later, that a few of the daughters of these women carry the risk of cancer caused by the stilbesterol. Or, we give cortisone to a child to relieve the agony and obstruction of regional enteritis, but this stunts the child's growth. It is "halfway technology." We, as a profession, do not know how to cure this illness completely. Transplantation is the same. We substitute one disease for another, with the best of intentions.

These two troublemakers, personal ignorance and general ignorance, follow

wherever we attend a patient. In the office or in the clinic, at the bedside or in the operating room these two familiar enemies lurk in the shadows, and forgive me Dr. Abrams, sometimes even in the x-ray reading room. We try to reduce their damage to an absolute minimum, but we cannot eliminate them completely. Some of our colleagues refuse to believe that these two apparitions exist at all. They blame their complications on someone else. "It was the nurse's fault, or the patient's fault." They prefer to care for patients and make rounds in a large pack or team, never alone. If there is an unfavorable result from a drug, no one is responsible. There are some surgeons who can never admit to any unsatisfactory results.

Probably the most benign form of escape from the clinical problem that puzzles us is simply to dismiss it with, "Oh, yes, we see this." The best example comes from the diary of Charles Nicole describing his discovery of the transmission of typhus. He was working in a hospital in Tunisia in the early 1900s during a raging epidemic of typhus that was highly infectious. Everyone in a household, or visitors to that household, caught the disease. But Nicole observed that patients in the hospital without typhus, next to typhus patients, did not catch the disease.

He asked his chief, "Why is this? Why, with a disease so infectious, do you not have to segregate the patients once they are inside the hospital?"

The chief answered, "We see this."

Nicole looked up the literature and found that this observation had been known for five centuries. For 500 years, seniors had been telling juniors on medical wards, "We see this."

Then, one afternoon while leaving the hospital, he saw a new patient being admitted with typhus, and he now rephrased the question. "Why is it when he crosses the threshold into the hospital is he no longer infectious?" He wrote in his diary, "I saw them take off the patient's clothes and put on a hospital gown, and I knew then that the disease must be in the clothes; it could only be a louse."

Thus, the habit of dismissing this puzzling problem with "we see this," stopped progress, in this instance, for 500 years.

At one time or another, all doctors are put in a position where they must pretend to know what they are doing. Often our patients force this posture upon us. The surgical personality epitomizes this "often wrong but never in doubt" attitude. Yet the airline captain has the same problem. He says, "Good morning ladies and gentlemen, we will arrive in Chicago at exactly 1:55." This is very reassuring.

Suppose he said, "I *think* we can get you to Chicago." You might want to change airlines or choose another pilot.

And then, at 34,000 feet, suddenly the breakfast trays leap into the aisle. The captain comes on: "Ladies and gentlemen, you may have noticed that we are encountering some turbulence." How quaint. He is totally surprised by it. It did not show up on any of his instruments. It is called invisible turbulence . . . idiopathic turbulence, but he does not act surprised. He is completely calm. He says "we see this!"

However, in the long run, it is better if we come to terms with the uncertainty of medical practice. Once we recognize that all of our efforts to relieve suffering might on occasion *cause* suffering, then we are in a position to learn from our mistakes and, most important, to appreciate the debt we owe our patients for our education.

It is a debt we must repay. We are obligated. It is like tithing. What do I mean by the word tithing? Medical tithing? It is easier to say what it is not. I doubt that the debt we accumulate can be repaid our patients by, for example:

- Trying to reduce the practice of medicine to a 40-hour week, or
- Dissolving the quality of our residency programs just because certain groups of residents in this country have refused, with the use of legal tactics, to be on duty more than every fourth night, every fifth night, or any nights at all, or
- Refusing to see Medicare patients when the state cannot afford to pay for them temporarily, or
- Going on strike.

But we can repay the debt in many ways; it is the urge to do this that motivates many physicians to:

- Attend postgraduate courses and seminars, or
- Be available to their patients at all hours, or
- Teach, or
- Take re-certification examinations, or
- Volunteer, maybe in the future, for national service, or
- Carry out investigation or research, perhaps the most difficult of all.

The individual who attempts to combine investigation with a clinical career, travels the toughest road, however fruitful. His counterpart in basic science thinks he is a dilettante researcher. His clinical colleagues think he is unsafe. And his mother-in-law says, "He's 35 years old and still working with animals. When will he be a real doctor?"

But why do I tell you this? You already know what I mean. I think we need to be reminded that these efforts are essential to our profession. Especially at a time when fewer and fewer of those entering our profession are willing to make much self-sacrifice, or williing to come back to the hospital at night, or be away from their families, or undergo the discipline required to be a first-rate physician or surgeon.

And it is a time when we need to let the public understand the uncertainties of medical practice. That "good clinical judgment is often acquired from bad judgment," and that we realize the debt we owe our patients.

That this theme is not well understood can be seen in the increasing inability of juries to distinguish between human error and outright negligence. Every simple honest mistake becomes a potential malpractice liability. There is the inability of our elected representatives to see hospitals except as public utilities, with patients labeled as customers. The terms "consumer" and "provider" assume that medical practice can be completely standardized. And then the Medicare laws tend to exclude physicians in training.

Do you remember the famous painting, *The Doctor*? Painted in 1891, a doctor in a frock coat sits in the home of a child who is dying of a disease at that time called typhlitis. Both parents in the background are deeply anguished. I used to show this to first year medical students, just out of college, and would ask them, "Tell me in one word, what does that picture mean?" Their usual response was "compassion." It meant the compassionate physician. But when I asked fourth year medical students, they replied, "bafflement." They said the patient really had appendicitis, but it was unknown at that time. The patient suffered from the state of general ignorance of the profession; his doctor sat by helplessly. This doctor's tithing was limited. He could only give compassion. Fortunately *we* are offered wider opportunities to tithe.

Compassion certainly, but also all of the other qualities that I have mentioned by which physicians should repay patients for their own education. Then we can say with peace of mind that we have earned the right to *practice* medicine.

Discrimination at Harvard

by Claire V. Broome '75

There is an issue that has been of concern to me throughout my four years at Harvard Medical School: the difficulties women face in entering a profession with a long tradition of overt discrimination against them. Sir William Osler, that father of so many medical traditions, rather neatly capsulized the traditional attitude to women in medicine when he said, "There are three classes of human beings: men, women, and women physicians." I do not wish to minimize the progress that has been made since that time in the most essential area, that of increasing the number of women in the field. Twenty-two years ago, the first twelve women graduated from HMS; this year's first year class is one-third women, and the recent report on the admissions process advocates a goal of parity. But the assumption that discrimination is therefore a thing of the past denies the strength of the deeply held attitudes responsible for the inequities in the first place, and unrealistically minimizes the problems facing women as they enter the field in increasing numbers. The real challenge to our generation of doctors is not just to permit superbly qualified women to become doctors, but to accomplish the full integration of women into the medical profession.

I would like to relate an anecdote that illustrates the complexity of the problem. A noted woman economist was the only female member of a Ford Foundation seminar. She participated actively in the discussion, as it was in her area of expertise. At the end of the conference, the chairman, a distinguished national government figure, concluded by summarizing the positions and contributions of all the participants except for the woman, attributing all of her remarks, including some very specific suggestions and criticisms, to another man. She was very disturbed at being tacitly ignored in this way, but wondered if she had misperceived the situation and was overreacting. Finally she wrote to the chairman describing what she felt he had done. In his reply, he wrote that at first he had totally disbelieved that he could have done any such thing, but after going over a transcript of the meeting, he realized that she was completely correct. He apologized profusely, and hopefully was more aware of his possible biases thereafter.

Dr. Broome

The problem of a professional woman being unable to communicate and receive credit for her ideas is serious. However, two other points raised by the anecdote are possibly more important: firstly, that the woman, a successful economist, doubted her perceptions of the situation and was not sure of the occurrence of discrimination; and secondly, that the chairman was totally unaware of his bias — that the episode was subconscious and not at all malicious. What I am trying to get at are the subtleties of such episodes, the strength and sub-conscious level of the attitudes, and the manner in which they can combine to deter women in professional careers. If the woman had not had the courage to challenge the chairman, and if he had not had the openness to examine the transcript and admit his mistake, the episode would have ended with the woman's self-doubt and the chairman's unawareness of her contributions.

I do not want to suggest that this sort of incident constitutes the universal or all-pervasive experience of women in medicine. However, the instances of discrimination, even those which may seem trivial, have a cumulative effect, and contribute to an atmosphere that complicates the already difficult task of integrating one's professional and personal identities. Evidence of the degree to which women students perceive that there is a problem is that in preparing its report, *Obstacles to Equal Education at Harvard Resulting from Sex Discrimination,* the Student Task Force of the Joint Committee on the Status of Women received accounts of one hundred incidents from fifty medical, dental, and public health students within several weeks — and you all know how difficult it is to get students to return forms. . .

These issues are too important and too subtle to be relegated to the medium of a brief, one-way communication (some might even call it a harangue) from me to you. Since the problem exists at the level of interaction among human beings, it needs to be solved at that level. And the problem is scarcely one-sided. Women have been conditioned by the attitudes of society just as much as men have. I think that changes in discriminatory attitudes will come about through increased sensitivity and openness in discussing these issues, and most importantly, through our ability to work together as mutually respected colleagues.

Reflections on Termination

Dr. Crowder

by Leonard E. Crowder '75

Graduation from medical school represents the culmination of twenty or more years of formal education. When one is finally recognized as an M.D. and is a notch above the status of an extern, there is a genuine sense of cerebral liberation and a generalized relaxation of sphincter tone. With the realization of the significance of this new role as physician, there begins a series of alterations in the attitude of the graduate with a concommitant change in interpersonal relations and the conduct of personal affairs. One's position as intern is now secure; one no longer need concern oneself with trivia, minutiae or basic science. Any questions one may have will be eagerly answered by the consultants and medical students. One may now be content to learn patient care unencumbered by the constraints of the past, of which the most burdensome was the trauma of a daily evaluation system.

It is an extremely satisfying feeling finally to be a physician after years of being a mere appendage to a ward medical team. There exists at this juncture a renewed impetus to contribute to patient care. The privilege of caring for the infirm is an idea appreciated early in medical school education; the right to care for them comes only at graduation. This new responsibility urges us to plunge forward and immerse ourselves in graduate medical education. The ability to manage the hospitalization of sick patients (even if to a limited degree) is a valuable and hard-won right not to be underestimated in its significance. We are eagerly desirous of that chaotic misadventure which is currently masquerading as internship. Our anticipation of future triumphs (and, alas, disasters) is overwhelming in these final days, since we are prepared to proceed with our postgraduate learning with the identical pertinacious perseverence that was mandatory for success in medical school.

The more perspicacious individual must pause and reflect on the impact of the last four years in an attempt to divine some deeper understanding of medical education and perhaps utter some profound wisdom which will guarantee success to subsequent medical students for years to come. Be it sufficient to state that there are many factors which affect the accumulation of medical knowledge. A not inconsiderable factor is the realization that there is an art to the learning of medicine that demands an elevated level of sophistication and maturity which is essential for the full development of a physician. The absence of bradyphrenia is also a prerequisite for a truly satisfying education. In no other profession must an individual learn to operate in so many varied academic arenas and develop early in training the ability to discriminate be-

tween important information and nonsense. This process usually begins on the very first day of medical school. It continues until specialty board certification is completed, at which time an altered method of cerebration is initiated.

Every student eventually finds it necessary to labor aggressively in the pursuit of his or her medical education. One may not content oneself to be a passive accumulator of data and expect to proceed in any field of clinical medicine. Achieving students must be unusually dynamic in their approach to learning. It is one endeavor to be a glorified graduate student and devour facts from a textbook, it is quite another circumstance to discern the rudiments of a particularly tragic pathologic process from a dying patient while simultaneously rapaciously digesting journal articles.

This fact was amply demonstrated during one of my early clinical interviews. The patient was a sixty-five-year-old obtunded obese woman in respiratory failure and on a volume respirator. She had a history of cigarette smoking of approximately one and one-half packcenturies and had recently quit on the advice of her physician. She developed bronchogenic carcinoma two months later, which her relatives attributed to the following of her physician's advice. Needless to say, the entire interview was a fiasco and I spent most of my time reading the chart. However, the principles of performing as a clinical clerk became firmly established that day.

There is occasionally an attempt among those departing to denigrate the system of medical education with a few well placed parting shots. Others quite rightly attempt to call attention to the deficiencies in instruction and evaluation that continue to persist in medical education year after year. There are specific areas in the basic and clinical sciences even at Harvard where students have been and remain unable to elute even minimally useful information. The most discerning students are at a loss in these areas, despite the prodigious production of course evaluations that allegedly are read religiously.

The formal education leading to the M.D. degree is a typhoon approach to medicine with a whirlwind introduction to the specialties. The years of intense study are insufficient to accommodate more than a partial cross section of medical knowledge. There are some areas that must necessarily be limited to a superficial exposure in the often minimal time allowed.

This is a time of extreme gratification for all graduating students. The degrees that we are receiving will remain of great value to us because of the tremendous effort we sustained in obtaining them. Minority medical and dental students in particular look forward to the limitless good we shall be able to accomplish in our respective professions. There should be a clear understanding that as minority students we have overcome unique obstacles in achieving our graduate status. We have maintained our integrity and perspective despite the occasional attitude that would seek to compromise our abilities to function as dedicated physicians and scientists. We have usually discouraged any attempt to restrict our capabilities to fully develop in the directions we sense to be important. Moreover, we have encouraged those aspects of medical education (such as social medicine, family practice, community health care, and so forth) which will tend to improve medical care for everyone.

During the past four years, there have been no foolproof guidelines which would ensure success. No particular method of approach was sufficiently broad to encompass the variety of circumstances in which we found ourselves. Notwithstanding, medical school remains a serious and worthwhile endeavor, and Harvard Medical School should continue to encourage and accept the enrollment of minority medical students. Despite the many current crises, we retain optimism for the profession. Moreover, the practice of medicine is less forbidding to us now than at the beginning of medical school. It is to be expected that most of us will continue to participate in some aspect of medicine despite whatever fiasco may befall the profession in the future.

A Doctor *is* a Human Being

by Julius A. Kaplan '75

I've had a good time here at Harvard Medical School and I want to tell you about that. I want to talk about my satisfaction in learning family medicine and my fulfillment in growing as a human being. With the invaluable assistance of my advisor and the registrar, both of whom have been a great help to many besides myself, I was able to develop an imaginative educational program that made learning exciting. It is this experience and my feelings about becoming a doctor that I want to share with you.

My clinical experience began not with medicine or surgery or pediatrics, but with a one-month preceptorship with a family physician in a community outside Boston. I cannot emphasize enough the importance of that month, for it gave me a sense of the knowledge and skills I needed to obtain, and I saw a hard-working physician who enjoyed his practice, his family, and himself. Entering the university hospitals, I began each clinical rotation by explaining to the house staff and attending physician what my goals for learning were during that month, and although they were not accustomed to having students approach them in this way, they were very responsive. My interest in family medicine, in the diagnosis and treatment of common medical problems, and in the management of the patient as a whole person, was generally supported, despite my fears about the subspecialty orientation of the physicians with whom I worked. More than anything, I was excited about learning, and so were the people around me.

And let me tell you about those people, because there is no question that, though often overlooked, the affective

Dr. Kaplan

personal component of education is very important. Relationships that developed between myself and the people I worked and played with influenced how much, and what, I learned. Physicians, nurses, patients, friends — without that human contact, without the sense of sharing ourselves, both inside and outside the hospital, I could not feel fulfilled in the way I do. We medical students are not empty pitchers into which scientific facts are poured and doctors thereby produced; we grow as physicians and as human beings in our education, and the two are inseparable.

Now consider that Harvard Medical School has been an enjoyable experience for someone who wanted to become a 'people doctor,' not someone interested in doing research or teaching in a university hospital. One of the assets of this medical school has been that, despite its hidden and sometimes overt bias against family medicine, it has offered the opportunity for students with a wide range of interests to learn. It is, therefore, disappointing that Harvard has allowed its own Family Health Care Program to wither away from lack of real support. The Family Health Care Program has been the only place where a student could get a longitudinal experience in caring for families, and it has been the only support for students interested in the rapidly growing discipline of family medicine. It is paradoxical how the Family Health Care Program could exist and flourish for twenty years, but at the time when the specialty of family practice is attracting more and more students, this medical school, as if threatened, could withdraw its backing and let the program falter. I am especially saddened because the program has been so instrumental in my enjoyment and the enjoyment of many students, whether or not they wanted to become family physicians.

Finally, a few words about what I have learned. All in all, three things stand out: I have come to know of the fulfillment in loving and sharing with people, I have begun to understand the importance of caring for myself in caring for others, and I have discovered the value of listening and learning.

We each have our own priorities in what we want from what we do. For me, sharing life experience with people has been most satisfying: I have given prenatal care to a woman and her family, then assisted her in delivering the infant, and watched the child and family grow; I have seen a previously very shy and withdrawn six-year-old suddenly open up and tell me all about herself and ask me what it was like being a grown-up; there has been the experience of watching and helping a middle-aged woman deal with the crisis of loneliness as her children left home; and I have talked for hours with a man who had severe chronic lung disease about life and whether it was worth it for him to continue living. These experiences reinforced my desire to be a 'people doctor.' To borrow from Walt Whitman's *Leaves of Grass,* "There is something in staying close to men and women and looking on them, and in the contact and odor of them, that pleases the soul well. All things please the soul, but these please the soul well."

I've also learned that to stay in touch with those people I have to stay in touch with myself. I have begun to know the need for being at peace with myself, the need for caring for myself even as I care for others. We physicians forget about that too often as we constantly struggle to give to people who come to us. We have to give to ourselves too, because we all need to be nourished apart from medicine, whether by taking a hike in the woods, or running around a pond in the late afternoon sun, or spending a full evening and night with someone we love. For when we can do that, our humanness deepens and we can come back to our practice of medicine with renewed spirit.

The final thing I've understood is the value of listening and learning. That sounds strange, I know, for I along with all of my colleagues have spent countless hours taking medical histories and studying. But the listening and learning I'm talking about now is different. In taking a medical history the need to get the facts down and make the diagnosis can take priority over listening to the person. We can treat the disease even when we know little of the person who has it. All things that we experience contribute to our ability to be physicians. Those of us with closed minds, those of us who approach persons or painting or poetry without sincere effort to learn and gain new perspective, limit ourselves as people and as physicians.

In closing, I must applaud this medical school for providing people with interests such as mine the opportunity to learn. Harvard needs a focus for family medicine, and it is hoped that renewed support or a new program will be forthcoming. I have learned a lot, and I am thankful. I hope that we may all continue to grow and continue to learn, and in doing so, become stronger, simpler, kinder, and warmer.

Above All, Do No Harm

by Victor C. Strasburger '75

The third year of medical school is the most difficult. With exposure to sick and dying patients for the first time, life seems to progress from bleak to bleaker to bleakest. The following excerpt from a novel-in-progress about Harvard Medical School reflects the worst of times. From there on, however, everything becomes clearer. And now, after four years of medical school, I feel I can honestly say that the great rewards of becoming a doctor seem well worth those initial days of despair, one of which I will now portray for you.

Dr. Strasburger

Going to medical school is like having cancer: you have to learn to live with the pain.

"Okay, DelMarva," said the attending physician as rounds began that morning. "Just give me the straight poop on this patient. I haven't got much time, you know."

Marvin DelMarva, third-year Harvard Medical student, felt a nearly overwhelming desire to wet his pants.

"You want the straight pap on the pootient? . . . I mean, I mean. . . "

"No, DelMarva, you blithering idiot. I want a rare roast beef on rye to go. And hold the mayo. Now are you going to tell me about this guy you admitted last night, or will I have to wait to read his obituary before I can learn anything about him?"

"Dr. Anderson," the intern on the ward team said. "This is Marvin's first clinical rotation, and he's been up all night working up this patient."

"Dr. Miller," announced the attending, wiping his gold-rimmed spectacles with his Harvard tie, "A team of women mountain climbers was killed yesterday trying to climb some goddamn mountain in Russia; seventeen Vietnamese civilians were accidentally blown to bits; the Red Sox lost a doubleheader last night; and my migraine is acting up. In short, life is difficult — for you, for me, for everyone. I am not an unsympathetic person, you understand. But either this kid presents this case to me now, or Harvard Medical School is going to have itself one vacancy in its third-year class. *Capice*?"

Marvin considered making a run for it. His tongue felt like a loaf of bread. His fingers tingled. He looked over at the other medical student on his ward team, Betsy Pomoroy, who was knitting and quietly smiling to herself in the corner. This all wasn't happening to him, he thought.

Tom Miller's hand on his shoulder urged him back to reality. "Go ahead, Marv. Just relax."

Relax, nothing. Do turkeys take a three-week vacation at the beginning of November?

"Mr. Stein is a seventy-two year old white married male who was admitted to the Harvard Community Hospital for the second time with what seemed to be a stroke."

"Son, are you asking me or telling me?"

There was no answer. Marvin was paralyzed from the mouth up.

"Good God, man. When your patients come to you with crushing substernal chest pain, nausea, vomiting, and sweating like Niagara Falls, are you going to say, 'Well, it *seems* like you *might* have had a heart attack'? You're a doctor, DelMarva. If you don't know what the hell's going on with your patients, no one will. Be positive. Be aggressive. Piss or get off the pot, boy."

"Mr. Stein," Marvin announced definitively, "suddenly fell to the living room floor of his third-story apartment one day prior to admission at 8:30 p.m. He has no prior history of a stroke, no history of seizures or alcholism."

"How do you know about the alcohol?"

"I asked him."

"And you trust his answer?"

Marvin nodded.

"You're not one of these fancy-pants Harvard College sociologists they've started letting into medical school, are you? What did you major in, son?"

"History of art. At Yale, sir."

"History of art? HISTORY OF ART! I knew it. We've got a *humanist* in our midst." He turned, wide-eyed, to Tom Miller.

"Don't look at me," Tom said. "I majored in comp. lit. at Stanford."

"I was an English major myself," said Reid Shaw, the senior resident.

"Gee-zus H. Christ. Now isn't this a pretty sight? Perhaps we should forget about discussing this case. We can send out for some tea and talk about something more interesting — say, Picasso's blue period, or Gertrude Stein's red period. Get it? Gertrude

Stein's *red period*?" He winked slyly at Betsy.

"I majored in advanced biochemistry and biophysics, sir," said Betsy, thinking that was her cue.

"Well, DelMarva. All I can say is, one of these days you're going to get burned. You should trust no one. Not even yourself. I'd hate to say how many patients I've seen who have come into this hospital swearing they've never touched a drop and who died the next week in alcoholic coma. You've got to be suspicious. More than that, you've got to be a goddamned detective. You've got to sneak up on them in the middle of the night and smell their breath. You've got to shake down all of their friends. Have you got this guy on something in case he D.T.'s?"

"He's not an alcoholic, Dr. Anderson," Tom said.

"Just checking. Okay, DelMarva, tell me why you think this guy stroked out?"

"Well, he's been in atrial fibrillation for at least two years, and I think he's probably thrown a few blood clots to his brain."

Anderson looked at Betsy. "Do you agree, Miss Pomoroy?"

"Not really. He could easily be having Stokes-Adams attacks. There's a good article on them in last month's *Annals of Internal Medicine*."

"You ever heard of Stokes-Adams attacks, DelMarva?"

"I remember hearing something about them in . . ."

"Tell him, Pomoroy."

"Stokes-Adams attacks are syncopal episodes resulting from a transient Mobitz-type II heart block with inadequate cerebral circulation. Treatment calls for insertion of a pacemaker," Betsy recited.

"Right you are, young lady. You ought to listen to your colleague here, DelMarva. You could learn a lot from her."

Marvin felt the call of the bathroom once again.

"Okay, humanist. Let's go see your patient."

As they left the conference room, Dr. Anderson slowly walked over to Marvin and put his arm around his shoulder. "It's okay," he smiled. "I had a Rhodes Scholarship at Oxford in medieval history."

Remarks

by Leon A. Assael '75

When dental education began here over a century ago, Harvard became the first American university to acknowledge that dental disease is a medical problem. Although the Dental School was formed at the invitation of the Medical School, dentistry was destined to develop as a uniquely separate discipline within the realm of medicine. This has resulted in separate courses, faculty, degrees, and professional identity for physicians and dentists.

Dr. Assael

This system has had distinct advantages. Dentistry has been able to provide care at a volume and level of skill that would not be possible if it were simply another medical specialty.

The system of separate professions has also created certain rather pressing problems.

Today, physicians at Harvard are trained with a poor understanding of the significance of oral disease. The mouth exhibits a diverse and complex pathology that should be understood by every physician. At Harvard Medical School there is only one optional lecture and no clinical clerkship related to the oral cavity.

A second problem is the lack of medical knowledge on the part of many dentists. At Harvard, dental students take all pre-clinical courses with the medical students. Hospital externships in dentistry and other subjects have given us greater confidence in the medical management of our patients. Unfortunately, dentistry as a profession has only partially followed Harvard's philosophy. Minimal medical education and continued emphasis on obsolete mechanical skills still characterize the education of many dentists. There are dentists in practice today who will not take an adequate medical history, will not prescribe necessary medication for their patients, and will not treat patients with even simple medical problems.

These deficiencies have, of course, been detrimental to patient care. This year over 10,000 Americans will die of oral cancer that was detected too late. Millions more will suffer from other problems related to inadequate dental care. While improperly trained doctors are only a small part of the health care delivery problem, it is a shortcoming we can correct within our universities. Increased integration of dental and medical education is a solution that will produce better health care for our patients.

I encourage you, my classmates, to realize that a healthy mouth is an integral part of a healthy patient. Learn about the oral cavity. Examine it. Take care of it.

This year, as last, the student speakers for Class Day were not chosen by their peers, by faculty members, or by any other pre-ordained method. It's a democratic selection — whoever feels motivated to espouse a particular cause or concern is entitled to speak at Class Day exercises.

Letters

Fewer Words, More Action

Your most recent issue was very stimulating.

Bruce Barnett '75 has done well to point out a serious problem. I can confirm his observations by saying that in a textbook of parasitology which I analyzed there were twenty descriptive facts to every diagnostic fact. Twenty to one: at this rate Barnett's 4,000-gram surgical texts would be expected to yield 200 grams of diagnostic information. Students cannot find this information easily even if they have the time — which, Barnett points out, they haven't.

The second item concerns the agonizing articles about medical school admission, which had many cogent ideas. I should like to add an idea which has been overlooked. Lest it sound like an impossibility, I can give references to working models which have been successful for over forty years. The idea: "cooperative work-study education" — three months study followed by three months of real work at a real job in a hospital or medically related institution. This would allow twice the number of able students to use the permanent facilities. It would alleviate the problem of financing medical education and it would make the medical student a productive part of the health care delivery team.

Bradley E. Copeland, M.D.
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Bicentennial Bravos . . .

My heartiest congratulations to the *Bulletin* and to Dr. Gifford, for the excellence of the Bicentennial Issue. I speak with feeling, as well as admiration, since as one of the editors of *JAMA,* I have the task of preparing a special bicentenary issue for next July. I hope I can carry it off as well as George has done.

Let us hope that this issue, and the companion for next year, will do much to vitalize the subject of medical history at HMS.

Lester S. King '32

I want to hasten and congratulate the editors on the March/April issue of the *Bulletin*. Without any question, as far as I am concerned, this is the best that I have seen. In view of the bicentennial it is most appropriate that medical history be emphasized, and I was tremendously interested in the article by George Gifford and comment by George Richardson.

I am particularly interested in this excellent edition of the *Bulletin* because since retirement on June 30, 1973, I have been devoting my efforts toward a monograph on "Infectious Diseases" under the auspices of the National Library of Medicine. This is historical in scope, and it has excited my interest considerably.

In summary, I have always enjoyed receiving the *Harvard Medical Alumni Bulletin,* and I will look forward to future excellent editions.

Wesley W. Spink '32

The March/April issue of the *Bulletin* is excellent and reflects outstanding efforts by the editors. I have a question, however, concerning the print of Joseph Warren on page 25. Can the editor or Mr. Cash identify the reference? I've seen several likenesses of Joseph, one of my ancestors, but never this particular one. Could it be of his brother or nephew?

Church Matthews, Jr., trustee of
the painting of Joseph Warren

The Bicentennial number of the *Bulletin* is a handsome and interesting production, and I enjoyed reading it. However, I feel I must call attention to an error.

The portrait on page 25 is not Joseph Warren, but his younger brother, John Warren.

This picture appears opposite page 130 in volume I of the *Life of John C. Warren* by Edward Warren (Ticknor and Fields, Boston, 1860), and as frontispiece of the *Life of John Warren* by Edward Warren (Noyes, Holmes and Co., Boston, 1874).

In the two biographies there is an inscription, "John Warren, Surgeon & Physician, Directing the Hospital, June 1783," below the picture. In the *Bulletin,* this picture has become reversed with the subject looking toward his right. There is nothing to indicate the origin of the picture. It is not the portrait by Rembrandt Peale that is in the Countway. The details of the collar and cravat identify the picture as the one that is in the biographies. I was not able to compare it with the portrait in the faculty room of the Medical School, as the faculty were having a meeting.

Richard Warren Dwight '28

Editor's Note: It is true that the portrait shown on page 25 of the March/April issue is of John Warren instead of his brother Joseph. We regret confusing their likenesses, and thank Mr. Matthews and Dr. Dwight for their perspicacity.

The March/April 1975 Bicentennial Issue is such a handsome and interesting one that I hate to quibble about small things gone awry. However, Nicholas Boylston has become a recent historical friend of mine and I would like to set straight the fact that he lived from 1716 to 1771 and not from 1721 to 1798 as is stated in the second paragraph of "Countway Portraits." It should be clear to any reader that the death date is wrong because Kenyon Bolton's article speaks of Boylston's legacy in connection with the Corporation's Commission to Copley in 1772.

William Bentinck-Smith